THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

Changes and Choices: A Psycho-educational group process for women identified by Child Welfare Authorities as 'at risk' of having their children removed due to substance misuse

BY

Adele L. Pobihushchy

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

of

Master of Social Work

CONTENTS

1) Learning Objectives and Goals of the Practicum

As a social work candidate of the Masters Programme at the University of Manitoba, my objective in this Practicum is to conceptualise, create and facilitate a group process for women who had been identified by Child Protection authorities as at risk of having their children removed due to their alcohol and other drug (AOD) problems. Ecological systems and addictions theories will be combined with a feminist analysis to inform and guide my work. Group theory as it relates to mutual aid, support and treatment groups will be utilized in the process and evaluation of the Practicum.

Specific objectives were:

- to review the current literature relating to women and addictions;
- to identify gender specific needs and issues in substance abuse treatment;
- to learn how to motivate and support women in a change effort;
- to learn how to identify and remove barriers to women seeking AOD treatment in the community of Prince George, British Columbia;
- to gain skill working collaboratively with women and the Child Welfare system with an aim of improving the relationship between them;
- to gain experience in evaluating the outcome of change efforts.

The benefit of the group process for the Child Protection workers was to provide assistance in assessing and implementing treatment objectives for the women on their case loads who were reportedly struggling with AOD issues. It was assumed that the benefits for the participants of the group would be the process of self-identifying their struggles with AOD and determining their individual treatment or resource needs to resolve the issues that brought them to the attention of the Child Welfare authorities. These goals were to be achieved through a supportive psycho-educational group process, in combination with the benefits that can be realised through mutual aid support groups.

2) A Definition of Terms and an Integration of Theories

For the purposes of this study, the terms: addiction, chemical dependency, alcoholism and substance abuse are considered to be interchangeable. To facilitate understanding and to avoid unnecessary debate, like Krestan and Bepko, (1989), I will use the term 'disease' when discussing addictions. While I respect the efforts of those who strive to ensure that clients are not labelled, I agree that "the Chronic Disease Model has yielded the most consistent treatment outcomes for the most clients" (Zuskin & DePanfilis, 1995, p.9).

My dilemma in adopting the term disease when speaking of addictions is that I do not want to pathologize women's experiences in coping with addictions, yet I have a strong belief in the efficacy of treatment methods based on the disease model. According to Bepko and Krestan (1985) the concept of addiction as a *disease* is based primarily on Jellinek's theory of alcoholism, in which he contended that chronic alcoholism is a progressive and potentially fatal disorder with a predictable prognosis if the alcoholic was left untreated. In this context, much like a diabetic, the addict/alcoholic is not responsible for *having* the disease, but *is* responsible for the treatment of the illness.

During the development of this project, I came to realise that it was not the *disease model* that I was endeavouring to integrate with feminism and ecological systems theory; rather it was the *disease concept* of addictions that would serve as a starting place for the treatment focus of the participants. The disease *concept* of substance abuse is substantially different than the traditional *medical model* of social work practice, in which individuals are treated for specifically labelled illnesses that have been diagnosed by an 'expert' with little regard for personal, environmental or societal influences (Barker, 1987). The position that an addiction is a disease and that certain people may be predisposed towards it, does not negate the role of environment or the context in which substance abuse occurs. Rather it demonstrates that diverse causes may result in substance misuse in an individual. These may include environment (AOD use in the family unit during childhood, poverty, lack of access to education, etc.), genetics (apparent biological familial predisposition), trauma (childhood abuse, battering, loss, etc.) and/or learned behaviour (using AOD ingestion as a coping mechanism).

In this Practicum I will endeavor to utilize relevant and applicable resources from the discipline of social work, addiction's knowledge, feminist theory and ecological

systems theories. These theories are compatible in that they all consider context. A fundamental principle of feminist theory is the 'personal is the political'. Social work emphasizes person-in-environment. Ecological theory is defined by its focus on the environmental contexts in which people function and the transactions that occur between people and their environments. Ecologically informed interventions are aimed at maladaptive processes and distorted communications within the transactions, rather than at individuals (Gitterman & Germain, 1989). Just as the environmental context shapes the person, the person reciprocally shapes the environment. This theory melds well with the social work goals' of strengthening coping patterns of people while simultaneously improving the environment to achieve a goodness of fit.

A feminist perspective ensures that change efforts are "grounded in recognition of the vital role played by social inequalities, especially as related to power or lack of power, and accompanying variations in self-esteem and vulnerability to substance use and abuse" (Abbott, p. 258, 1995). Due to these inequities of power, feminist empowerment techniques are essential. "Empowerment refers to the process by which individuals gain power, access to resources, and control over their own lives" (Robbins, Chatterjee & Canda, 1998, p.91). Operationally, empowerment means working with women collaboratively. It means respecting and admiring women's strengths and providing the 'mirror' to reflect back the power that is already within them (Glen Maye, 1998). Finally, for women in this population to be empowered, the system (the Child Welfare authority) that has been assigned ultimate power must be prepared to share it.

As an adjunct to therapy, many helpers encourage referrals to Twelve Step, self-help programs, such as Alcoholics Anonymous (AA) or AlAnon. (Bepko and Krestan, 1985; 1989; Chappel, 1992; Pasick and White, 1991; Schaef, 1992). These programs are based on the disease concept of addictions. Ecological theory concurs with such referrals by suggesting that enhancing social networks which are close to the life processes of individuals is likely to be more worthwhile than formal support over a life span (Gitterman & Germain, 1989).

Finally, my thinking and planning was also influenced by Imber-Black who suggests that "assessment of the family-larger system relationships can help to uncover patterns of conflict or pseudo-mutuality between the family and helpers that may impede therapeutic process" (p.586). When two systems in the macrosystem are in conflict about the

treatment of a woman, as often happens with Child Welfare and addictions services, this situation can create triangulation. She then becomes like the child of two warring parents. Ultimately, this can result in her inability to work with either system without risking the alienation and displeasure of the other. The dysfunctional triangles in her family system are replicated in the macrosystem. Blaming, avoiding responsibility and gossiping are the primary focus, rather than directly addressing any areas of conflict or cross-purposes. This 'in fighting' wastes already limited resources, to the detriment of all involved. The goal of the integration of these theories is to provide a deep understanding of the factors that contribute to women's misuse of substances that will help to target change efforts.

3) A Review of Selected Literature Pertaining to Women and Substance Abuse

The need for gender-specific programs becomes clear when the statistics of AOD use are studied. Women with AOD addictions comprise from one third to one half of the population of AOD abusers according to Lester (as cited in Burman & Allen-Meares, 1991). AOD addicted males by contrast, even when corrected for prevalence, were found to be four times as likely to enter treatment as AOD abusing women when only public funded facilities were considered (Beckman & Amaro, 1984/85). In 1982, Beckman and Kocel revealed many system-related barriers, including a lack of adequate daycare facilities or treatment centers that allowed admission of women with children. Yet little has been done in over more than a decade and a half to improve these conditions. Many current studies still cite this deficiency of childcare as one of the greatest inhibitors to women's recovery (Burman & Allen-Meares, 1991; Finkelstein, 1994; Nelson Zlupko, et al, 1995; Wilke, 1994).

An examination of the research also provides a rationale for gender specific treatment resources for women. Women are more likely to begin to use substances heavily after traumatic life events (Nelson-Zlupko, Kauffman & Morrison Dore, 1995). Women experience quicker physical impairment from alcohol than men do and they move more quickly through the progressive stages of the disease, a process called 'telescoping' (Nelson-Zlupko, et al, 1995; Wilke, 1994). Men tend to have behavioral problems as a consequence

Changes & Choices

A Psycho-educational group process for women identified by Child Welfare Authorities as 'at risk' of having their children removed due to substance misuse

By Adele L. Pobihushchy

A Practicum

Submitted to the Faculty of Graduate Studies

In Partial Fulfilment of the Requirements

For the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

of excessive drinking, such as assaults, drunk driving, criminal activities etc. Women tend to experience more interpersonal problems from substance abuse, such as arguments with family and friends, and civil actions such as landlord-tenant disputes (Nelson-Zlupko, et al &Wilke, 1994). Sutker (as cited in Nelson-Zlupko, et al) found that while men in treatment were often involved in robbery and burglary to maintain their habits, women in treatment reported relying on shoplifting and prostitution. Women tend to turn their emotional pain inwards, often becoming depressed instead of angry. The tragedy of this inward focus is that women suffering from untreated chemical addiction may sell their *own* body and risk their *own* home before violating someone else's.

Women with AOD issues experience more pronounced levels of guilt, shame, anxiety and depression about their addiction than do their male counterparts (Burman &Allen-Meares, 1991). They encounter anger and blame from society; particularly for issues relating to child abuse or neglect and for the potential damage to the fetus from AOD use when a women is pregnant (Finkelstein, 1994). Additionally, women are at higher risk of developing eating disorders than men, a consequence of lower self-esteem and poor body image issues. Women are more likely to be on public assistance, living below the poverty line, yet they are also most likely to be the primary caregivers of children (Finkelstein, 1994; Wilke, 1994).

Childhood sexual abuse, intimate partner violence, reproductive dysfunction and marital disruption are all factors related to alcoholism in women (Nelson-Zlupko, et al, 1995; Wilke, 1994). Histories of AOD abusing women often relate injurious and painful relationships with men, whether partners or family members (Finkelstein, 1994). It would be difficult to separate a woman's AOD use from her relationships in which her abuses of AODs (and ultimately herself) are embedded.

Historically and currently, women with addictions have been considered 'sicker' than their male counterparts, and therefore more difficult to treat (Bepko & Krestan, 1985; Nelson-Zlupko, et al, 1995; Wilke, 1994). This gender discrimination is reinforced still further by societal constructions that portray the AOD addicted woman as sexually promiscuous. "Drunkenness and drug use in women is not simply associated but is equated with 'rampant sexuality' and promiscuity"(Finkelstein, 1996, p.33). This can result in women AOD users being viewed more negatively than are their male counterparts because commonly held beliefs prescribe stereotypical roles which demand asexual purity from women in general and mothers in particular (Finkelstein, 1996). For instance, 'Mother

Theresa' and the 'Virgin Mary' are revered for their sexual purity and self-sacrificing natures. This entrenched bias results in more and greater social condemnation and a correspondingly higher level of social stigma. Such portrayals of AOD using women combine to create system responses which are predominantly punitive in nature.

The treatment process itself can be a source of additional stigma. Treatment may be seen not as a solution but as yet another problem to be avoided. Many women fear that they will lose their children and be singled out by Child Welfare authorities if they seek treatment for their addictions (Aiken & Gregoire, 1997). If they do seek treatment, gender specific centers are rare and it is probable that they will be greatly outnumbered by men in the treatment setting. Research of treatment group dynamics cited by Wilke, (1994), indicates that in coed groups, women will be interrupted and 'talked over' more often than men. Men often subtly manipulate and silence women without being aware of it and generally men talk, and are listened to, for longer periods of time than women. Additionally, women are more likely to be tentative or non-assertive in their participation in conversations, especially when they are with predominantly male groups. This is often perceived as uncertainty, making the assertion of self even more difficult when they are in mixed company (Wilke, 1994).

Since women's experience with the addictive process is inevitably embedded in relational issues, then a model which considers relationships that maintain and exacerbate addictive behaviors becomes both necessary and appropriate to responsibly address the addiction and its causes. Finkelstein (1994) discusses the 'self-in-relation' theory of development that was advanced by a group of women under the leadership of Jean Baker Miller at Wellesley College. According to this theory of development, *connections* are seen as essential to psychological development and healing. AOD abusing women are seen as suffering from multiple *disconnections.* As a woman's sense of well being is based on connections with others, AOD abuse may be a response to the anxiety and pain that results from these disruptions in relationships (Bepko, 1991; Finkelstein, 1994; Wilke, 1994). These theorists cite studies that indicate that women who abuse substances more often have a family history of loss, deprivation, abuse and rejection than do AOD abusing men. These negative experiences may include the loss of a parent through divorce or death, abuse as a child and/or as an adult, and a lack of role modeling due to parental inaccessibility caused by substance abusing or affected parents (Bepko, 1991, p. 417).

As Bepko points out, the double bind inherent in gender relationships is that they support both inequality and addictions (1989). For instance, the typical under-functioning of males in family maintenance activity and emotional expression encourages the consequent over-functioning of females. This indenturing of the female is reinforced by another double-bind: the supposition that men are 'autonomous' yet 'entitled' to be cared for, while women as supposed 'dependents' are contrarily expected to be the caregivers. "Addiction has been one response to the pain created by the incongruity in our social design" (Bepko, 1989, p. 411).

The review of this literature provided me with an understanding of the general themes affecting women who misuse substances. It was clear that the relational context in which women develop and maintain dependencies would need to examined and targeted for change. The function of substance misuse in unbalancing family systems and allowing restrictive gender roles to be discarded (albeit momentarily) suggests that empowering and consciousness-raising techniques may help women feel entitled to take time for self in less destructive ways. Furthermore, empowerment techniques may also help women with addictions improve their relationships with the institutions in their lives, most notably in this case, Child Welfare. If women are to work *with* Child Welfare authorities, then the enormous power imbalance between them needs to be addressed. The following section will explore this imbalance and consider solutions to enhance the relationship between women who struggle with addictions and the Child Welfare authorities.

4) A Review of Selected Literature on the Child Welfare Response to AOD Abuse in Women

Azzi-Lessing and Olsen (1996) cite studies by the Child Welfare League of America (1990) which indicate that substance abuse is an issue in as many as 80% of substantiated cases of child abuse and neglect. Additionally, they found that parental substance abuse is one of the three most commonly cited reasons for children entering care. In Prince George, British Columbia, the Ministry of Children and Families (MCF) case files are indexed using the mother's name, reflecting the reality of who is identified as the principle care giver. Consequently, it may be inferred that in most cases of children

coming into care, it is arguably, the mother who may have unresolved substance abuse issues. If the children's father were the AOD abuser, the children would likely be deemed safe, as the primary caregiver (mom) is still available.

> "Even if the father is present, the mother is still expected to be the primary caregiver, and the onus for recovery will be on her. She will be expected to choose a recovery program, to follow through and to maintain sobriety. The worker may have difficulty understanding how a woman could fail in this attempt, given that her children's lives are at stake... We assume that the mother can be cured if she chooses, and that the joys of children, the rewards for a mother of having them with her, should constitute sufficient motivation to overcome addiction" (Swift, 1991, p.257-258).

Swift (1991) asserts that the common thread that is recognized by all those who study neglect is poverty. Callahan (1993) concurs with Swift and states that neglect issues in Child Welfare are primarily attributable to a lack of resources in families. Finkelstein (1994) explains that the feminization of poverty is principally caused by the increase in female-headed families and that the many stresses of poverty increase the risk of substance misuse and depression. However, as Swift (1991) points out, it is not the mandate of Child Welfare to protect children, or their mothers, from poverty.

With substance misuse, concerns of neglect are exacerbated by the fact that the addiction requires money, which further drains limited family resources. Thus, what manifests, as neglect in a low income home would not be considered problematic if the financial situation allowed for appropriate caregivers for the children during binges and adequate resources to sustain the household. Azzi-Lessing and Olsen (1996) explain that due to the involvement of Child Welfare, the standards for these impoverished moms are higher than the standards set for the general population of substance misusers. Normally, addicted people benefit from the clinical wisdom regarding the predictability of relapse that has grown among agencies treating addictions. Yet, Child Welfare authorities often demand complete abstinence from these women, and the consequences for non-compliance may be severe.

Despite the demonstrated and identified need, these mothers remain hugely under-served and under-resourced (Azzi-Lessing & Olsen, 1996, Beckman and Amaro, 1984, Finkelstein, 1997). Residential treatment is cited as an essential component of comprehensive recovery plans, yet mothers with child care responsibilities are seldom

referred by professionals (Azzi-Lessing & Olsen, 1996, Beckman & Amaro, 1984) who are aware of the potential costs of treatment when children and their care are involved. If they are referred, women are in the minority once they enter treatment and often, they do not complete the program. (Azzi-Lessing & Olsen, 1996, Beckman and Amaro, 1984, Finkelstein, 1997). Additionally, *if* there is a referral and *if* there is a resource available, it is unlikely that the woman will be supported by her spouse in her attempt to attend treatment (Azzi-Lessing & Olsen, 1996; Finkelstein, 1994; Finkelstein et al, 1997).

Due to the dearth of AOD programming that exists for women, particularly in remote communities such as Prince George, the Child Protection worker assumes a pivotal role in the identification of substance abusing mothers. Often, it is only through the Child Protection worker that assistance can be found to access recovery resources (i.e. childcare during treatment, bus pass, respite for meetings, etc.). Aikin and Gregoire (1997) identified specific biases found in Child Protection workers and agencies that may inhibit women's recovery process. For example, these researchers illustrate how the negative societal perception of addicted women results in increased stigma for women and a consequent decrease in help-seeking behavior. If a woman is perceived to be *choosing* to harm her children in this way, then the response may be more punitive than the response to someone with a mental health disorder or a disease that affects positive social functioning.

Female addicts studied by Aikin and Gregoire, suggested that care givers and workers:

- "Be open and honest in delineating mutual expectations...
- Use language that clients can understand...
- Demonstrate support and care through behaviors...
- Help clients get the resources they need, such as housing, childcare and transportation ...
- Listen to parents' stories, opinions and aspirations...
- Maintain a hopeful and non-judgmental attitude...
- Share power and provide clients with choices...
- Help clients set incremental goals...
- Find ways to understand the nature of addiction and to know the parent as a unique individual" (Aikin and Gregoire, 1997, p 401).

The themes that emerged clearly from the suggestions made by these women reflect the basic tenets of good social work practice and illuminate the deficiencies present in current practices in Child Welfare agencies.

Carten (1996) cites work, by Edelman, (1987) and Hewlett (1991), that identifies components of successful programming for high-risk AOD families that include:

> "a focus on early identification and prevention, location in communities with the highest need, easily accessible and comprehensive services, parent involvement and empowerment, a focus on family strengths, staff functioning in multiple roles using culturally competent interventions and non-intrusive and non-stigmatizing interventions" (Carten, 1996, p 221).

It seems apparent that both clients and theorists concur about what is needed and helpful.

Evan Imber-Black (1991) discusses the mirroring of internal family processes by family-larger system interaction. Just as the smaller system (the family) may adopt dysfunctional solutions to problem solving, so too the macrosystem (in this case MCF) is not immune to dysfunction in its attempts at resolution. A common example cited by Imber-Black is the transaction between the family's response to intrusions by the macrosystem, which may include withdrawing and hiding. This behavior of being unavailable and secretive (distancing) may result in the larger system pursuing the family. When they do connect, the interaction is anything but positive, setting in motion a cycle of distance - pursuit - distance -pursuit in the micro-macrosystem interaction (in Gurman and Kniskern, 1991, p.589). Experience working for MCF convinces me that with substance-abusing moms, this response often degenerates into a frustrating game of hide and seek.

There is habitually and invariably a reluctance to share client information between Child Welfare agencies (CW) and substance abuse treatment agencies (AOD agencies). Confidentiality concerns can inhibit communication between addiction specialists (whose focus is on the individual woman) and Child Welfare workers (whose main interest is the well being of the children) (Azzi-Lessing & Olsen, 1996). Comprehensive recovery plans for women may suffer from these interagency communication shortcomings.

The preceding review of specific literature provided a theoretical base for the Practicum student and consideration of the foregoing knowledge helped to provide structure and content for the group process, as will be demonstrated in the following sections.

5) Group Planning and Formation

a) THE GROUP SETTING

The Practicum was completed at the Beech Crescent Community House, a newly opened resource of the Westwood Office of the Ministry for Children and Families, in Prince George, B.C. The MCF in Prince George has one community development position and the social worker in that position started the community house in June of 1997. The house is located in a row townhouse project that is in area deemed as a 'high risk' area due to the numerous incidents that require intervention by both Child Welfare authorities and police.

This rented facility is a three-bedroom townhouse unit. Concrete resources for the neighbourhood include a washer and dryer, a phone, a computer with word processing, a lending library, room for childcare services during adult program times and a clothing exchange. The kitchen is available to all and is well used.

The community development philosophy allowed for the members of the community to determine the types of services and programs that were relevant to the needs of this 100-unit structure and the surrounding residential area. One of the needs identified by the residents was programming for addictions, so the women's support group was congruent with the requests from the community. It was anticipated that there would be referrals to this study of women already using the house for other services but this was not the case. None of the women using the community house had been identified by the Child Protection authorities as being at risk of losing their children due to their own substance misuse. If there were heavy users in the neighborhood, they were not visiting the community house, or their use was well hidden.

Utilizing the community house for the group had many therapeutic benefits. The physical familiarity of the unit for many of the participants (the type of housing that they were used to living in) provided an immediate comfort that an office setting could not hope to attain. The women did not have to come through a reception area or another intake process. The kitchen was close to the entranceway and without exception all of the women quickly felt comfortable and by the second session they would help themselves to coffee and feed their children without asking for permission. On arriving for the second session, one participant opened the front door and yelled "hi, honey, I'm home!" I suspect

that it would have taken a lot of work to arrive at this level of safety and trust in another more institutional setting.

As the house also provided services such as laundry facilities, this enabled the women to perform some of their household responsibilities before and after group. The accessibility of the phone was a bonus for several of the women who did not have one in their own homes. They were happy if they arrived early and could take care of some business before the group started. The phone (which has a toll restricter) was on an end table and permission was not needed to use it. All of the rooms of the house were open to the women and often they clamored to check the new arrivals in the clothing exchange prior to starting group.

The Day Care staff and the women from neighborhood, who sometimes came in contact with the participants, were at similar socioeconomic levels as the participants. This homogeneity of financial and material situations appeared to facilitate a sense of belonging for participants. They shared many of the same issues and were able to trade hints on local bargains or solve problematic issues with 'slum' landlords, housing and utility companies. Some of the women knew the welfare system and taught the others the availability of crisis grants, how to access formula for babies and where the best food banks were. As a working professional, I was not as knowledgeable in these areas and only had a theoretical or superficial knowledge of the practical skills necessary to surviving poverty. This type of interaction illustrated the worth of mutual aid. I found that I was much more effective when facilitating the exchange of ideas and information than when trying to lecture, instruct or to come up with the answers on basic survival skills with this group by myself. Clearly, these women were the experts in this area and whenever possible, I genuinely commended their resourcefulness and pointed out how helpful their suggestions were to each other.

b) GROUP SIZE

A group size of eight to ten women was thought to be the optimal size for facilitating this type of intervention process. While a co-leadership model may have been theoretically preferable for this process, practical considerations precluded its use in this format. With the limited availability of qualified people to responsibly prepare and participate in the co-facilitator role, this format proved impossible. Consequently, eight group members were thought to be a manageable size for a single facilitator. This size of

group would allow adequate interaction while still being small enough to develop a sense of cohesion among its participants (Schneider Corey, M. & Corey, G., 1992). In light of anticipated attrition, an initial selection of twelve women was thought to be prudent to ensure a final adequate working group size.

c) PARTICIPANT REFERRALS AND SELECTION CRITERIA

All of the women referred to the group for consideration were at risk of losing, or had lost, their children due to AOD misuse. Consequently, they could not be considered 'voluntary' participants. Rather, they were complying with the Child Welfare authority letters of expectation or supervision orders. This factor was pertinent and notable, as it is a commonly held belief in the addiction's field that a person must 'choose' to enter the recovery process, usually after 'bottoming out'. Determining the level of client motivation is typically an integral part of the assessment process for individuals seeking treatment for alcohol and drug (AOD) issues. This 'hitting bottom' theoretically creates a crisis, and an attendant opportunity, which allows a breakthrough in the powerful denial system of the addict/alcoholic. However, for this Practicum I hoped that the external threat to the unity of the participant's family system would equate to, or *be*, the bottom that would induce the crisis and precipitate the desire for change in the woman. The group process assumed that once a woman was identified as a substance abuser by the Child Welfare authorities, the intrusiveness of the investigation and the status role change (being identified as an inadequate mother) would result in a situational crisis. "Such situational crises have an immediacy and enormity of demands that distinguish them... They often require immediate mobilization of the environment and of the individual in order to prevent collapse" (Gitterman & Germain, 1989, p.116).

During the initial referral and recruitment process, the essential concepts, logistics and expectations of the proposed Practicum were introduced to a team of seven Child Protection workers (C P W) and the District Supervisor (DS). The key elements of this process were communicated in a letter to the DS. (Appendix iii). The criteria for selecting referrals and a referral form were also included, thus providing each worker with a comprehensive package for review and discussion with suitable clients. At this meeting informal screening discussions were undertaken with the Child Protection workers as they suggested potential candidates from their caseloads. During this meeting I was struck by the expressions of anger, frustration, despair and hopelessness by some of the workers towards

their addicted clients. As Swift (1991) indicates, quite naturally Child Protection workers believe "an alcoholic mother means poor care for the kids" (p.257).

A punitive attitude surfaced when several workers took the position that these AOD misusing women *chose* to abuse substances, rather than to care for their children. Therefore, they *deserved* to have the children removed from them and placed in care. Histories of repeated failures to maintain sobriety were used as irrefutable proof of a client's lack of motivation and /or commitment to a Child Protection worker's Plan of Care for them. Little or no understanding was shown for the tremendously powerful pathology of the denial process, for the enormity of the changes requested, or for the existing barriers that the women had to face and somehow overcome.

This lack of understanding or empathy was typified when I suggested that these women would need bus fare to enable them to attend the required self-help meetings. One worker replied that her client "has cable television and she can have that cut off and use the money for a bus pass if she really wanted to get sober." In reality, this woman lived in a small under-furnished home with three children, no means of transportation and no telephone. Their cable TV was their principle source of family entertainment and (albeit one way) communication. Her family of origin was living 'back on the reserve' and substance misuse there was a pivotal issue in the extended family. Therefore, they were not a realistic source of support at this time. If this particular client were suffering from diabetes (and a corresponding need for daily treatment) instead of a chemical addiction, I strongly suspect that this worker would be more resolute and less judgmental in her efforts to advocate for resources (certainly bus fare) for this client. This illustrates a classic example for the need and requirement to address substance abuse as a 'disease' (Aiken & Gregoire, 1997; Azzi-Lessing & Olsen, 1996).

d) REFERRAL SOURCES AND GROUP COMPOSITION

I was both surprised and disappointed when the initial team approached did not generate enough referrals for the group. Early in the selection process, the team members spoke of the prevalence of substance misuse, in their caseloads (reputedly up to 70% of an average of 45 cases per worker). Only three of the initial seven Child Protection workers approached referred to the group. There were no referrals from the remaining four workers. This imbalance in the referral process was not examined in depth. It may have been the

result of individual worker's knowledge, attitudes, assessment skills and experience in working with AOD clients. Referrals also seemed to equate with individual workers beliefs about the ability of substance abusing moms to change.

This lack of referrals necessitated a postponement in the start date of the group while additional referral sources were sought. Initially, I hoped to draw from the MCF office located in the neighborhood to ensure that the selected clients would be within walking distance of the community house where the groups were to be held. Ultimately, Child Protection workers from another office referred four of the twelve women

Of the total referral group of 13 women, two are not included in further discussion as I was repeatedly unable to connect with them or establish any communication. In effect, the referral pool was only eleven strong. Nine of the women referred identified themselves as First Nations' people. Two were non-native. The women ranged in age from 18 to 35 years. Of the women initially assessed, none had achieved more than a grade nine level of academic schooling. None of the group participants were employed or in a school programme and all of the women were dependent on government financial assistance. Two of the group members spoke of prostituting to support their and their partner's addictions. Less than half of the 11 women assessed had telephones. Most lived in substandard rental accommodation, some with multiple roommates. None of the women had their own vehicle. This is particularly significant in Prince George, as public transit is limited, running only six days a week with very few evening runs.

Two of the 11 women had one child, two had two children each, five women had three children, one participant had four and another member had five children. None of those who were separated from their spouses reported receiving support payments from the children's fathers. Five of the eleven women had had their children removed by Child Welfare authorities. Three of these women had their children placed with members of their immediate families and two had children in foster parent and group home placements.

Three of the women had been previously referred to treatment and had completed a residential programme in the past. None of the participants attended self-help groups such as AA or NA on a regular basis, though several had been to one or two meetings in the past.

Referral Base for Possible 'Changes & Choices' Group Participants

Provided by: British Columbia, Ministry of Children & Families, Child Protection Workers

Referral	Age	Native (N) /Non (NN)	# of Children	Status of Children	Attended the Group	Prior AOD Tx.	Had a Phone
1	35	N	5	4 Foster, 1 Home	Yes	Yes	No
2	34	N	4	All at Home	Yes	Yes	Yes
3	20	NN	1	All at Home	Yes	No	Yes
4	20	N	2	All at Home	Yes	No	Yes
5	19	N	1	All at Home	Yes	No	No
6	29	NN	2	All at Home	Yes	No	Yes
7	18	N	3	All Foster Care	No	No	Yes
8	18	N	3	All Foster Care	No	No	No
9	25	N	3	Family Placement	No	No	No
10	29	N	3	"	No	No	No
11	27	N	3	"	No	No	No
12	NA	NA	2	"	No	No	No
13	NA	NA	1	"	No	No	No

e) THE DYNAMIC BETWEEN THE GROUP PARTICIPANTS AND MCF

It would be very difficult to overstate the influence of Child Welfare involvement on the lives of this group of women. In many ways, this involvement created a distinct sub-population of women struggling with AOD issues, whose overriding response to the Ministry's presence was fear, and consequently, an emphatic denial of the reports of AOD use. A distinct double bind or 'Catch 22' was operating against these women. If a woman admitted she had a current AOD problem, she expected to lose her children to the authorities. Conversely, if she did not admit to her addiction, how could she accept the services offered to help her recover from it? This was the personal conundrum facing all but one of the women, and consequently it was my starting point with each of them. In the majority of cases the women would state to the author that there *had been* reason for concern previously, but that after the initial intervention they had changed their lifestyles and had dealt with their problem. There was one exception. She had recently been through treatment and was having difficulty staying clean and sober, and had requested help from her Child Protection worker who referred her to the group.

Five of the six women who did commit to and attend the group had their children living with them under supervision orders. One of the regular group members had lost four of her five children, who were residing in group home and foster placements while her teenage daughter still lived with her. Significantly, all five of the women who had their children removed and placed with family members, (in 4 of 5 cases, the maternal grandmother) chose *not* to come to group. Perhaps knowing that their children were in 'good' care with open access to them, the motivation to change through participation in the proposed group was not sufficiently strong. One of the referrals, a 19 year old woman whose 3 children were in foster care accepted a referral to the group and committed to the process but after 3 efforts still did not respond to the vehicle sent to pick her up. Another woman whose children were with a maternal aunt presented as very motivated to attend the group during the case conference with the Child Protection worker. However, she did not respond to three attempts to pick her up for transportation to the group.

It became evident that the relative level of motivation for each potential participant was not necessarily predicated on recognition of AOD issues, but perhaps on the perceived situational dynamic of their children. This suggests several explanations. After the children have been removed from the mother, it may be too late to intervene. This further supports

the premise of early interventions in the addictive process as being most effective (Aiken & Gregoire, 1997; Beckman & Kocel, 1982; Bepko, 1991). Additionally, the AOD mother may not perceive the removal of the children and their subsequent placement with their grandmother as a 'bottom'. The transfer of the children into a home where there is open access may enable the woman to continue with her addiction without the responsibilities of caring for her children. Having the children living with a close relative may have less stigma and loss associated with having the children 'put in care'. It is also quite likely that the motivation to change is dissipated, and addictions are exacerbated by hopelessness once a woman has lost her children, regardless of whether they remain within her immediate family or not.

f) INITIAL CONTACT

During the intake process, a Child Protection worker provided a brief verbal history of the woman's involvement with MCF, along with the phone number or address of the candidate. I had initially requested and anticipated an introduction or a phone call to the potential participant by the Child Protection worker. With one exception, this did not occur, primarily due to the lack of telephones. Consequently, several 'referred' women were completely unprepared for me to approach them. Two of these women refused to come to the door to speak with me, after another adult had responded to my knock. These women no longer had their children with them. By way of introduction, I initially dropped off an intake package for each woman and if they were home, I would endeavor to introduce both the intake package and myself to them (Appendix V).

For those women who did not respond, I continued to try to connect with them by phoning or driving by their residence and dropping off messages. Over a period of three weeks, I made at least six attempts to connect with each woman. For those women who agreed immediately to attend the group, I continued to stay in contact with them twice each week to maintain interest until the group sessions started. I sought to engage them by showing sincere interest in how they were doing, apologizing for the delays and trying to help them clarify their situation with the Ministry through advocating to resolve concrete problems.

Other factors for analysis during this stage included the relationships two women had with their spouses. These men acted as gatekeepers by answering the door and preventing me from seeing the women initially. They also became transmitters of the

information I was trying to communicate. At the time of intake to the group, it was predominately these men who were doing the bulk of the child care, due to their partners using hard drugs and being absent from the home. To engage the females, it was necessary to develop a trusting relationship with these partners in order for them, (now the most willing member of the system to participate in the change process) to encourage and support their partners to attend the group. Both male partners had recently been incarcerated and one was wearing an ankle bracelet for surveillance. Both males had probation orders that demanded abstinence from substances, enforced through random urine samples. These factors acted as deterrents to substance use and motivated the men to want to change. The women, however, did not have the same conditions imposed upon them. After I connected with them, they expressed that they had carried the entire burden of the family during the jail sentences and now deserved a break from familial responsibilities. Bepko and Krestan's analysis of addictions in family systems explains the changes in 'over/under functioning' that occurred in these two family systems. As both over and underfunctioning are restrictive roles, they lead to feelings of inadequacy, anxiety, intense suppressed anger and low self-esteem. Addictions provide an avenue of escape, albeit only temporarily. "The over-responsible person may overfunction to deny dependency or may drink (become under-responsible) to relieve the pressures of the over-responsible role" (Bepko & Krestan, 1985, p32).

During the intake process, it became clear that the protection workers felt that they only had the authority to request that a woman not use substances while caring for her children. There is an assumption in this request that the woman has control over when and how she drinks or uses drugs. This is inconsistent with the concept of addiction, in which there is a lack of control over one's relationship with a substance. For instance, previous intentions to only have one drink or to spend only a small part of the family resources on substances have obviously been inadequate or MCF would not be involved. The only alternative theory is that these women consciously choose substance abuse over the safety and well being of their children. I am unable to subscribe to this notion, particularly in light of the affection and love they expressed for their children. Whether a woman used in the home or not, resources for the family were likely to be quickly drained to cover the costs of substance misuse. As well, this repeated time out of the home and the consequent

hangovers or detoxification periods were harmful cycles to the involuntary participants in the addictive process - the children.

This process resulted in a 'cat and mouse' game; the worker was dependent on reports from neighbors that there were problems or on 'catching' the mom impaired. The mom was intent on not getting caught, or on disproving and discrediting the neighbors, rather than focusing on self. In the case of hard drug use, many workers felt that they did not have the knowledge to determine if the woman was actually 'high' (or not) during home visits. Certain drug misuse, such as unregulated doses of codeine (a highly addictive substance) that is available 'over the counter' at any pharmacy, was minimized and not challenged as it was legal and considered to be innocuous.

During this referral process, the many missed appointments and the apparent avoidance tactics became frustrating. It was difficult to remember that 'resistance' is not an individual client's problem when working ecologically, but rather a transactional process. I needed to remember the patterns of relating that had been established between these women and MCF. In overcoming these obstacles I was exposed 'first hand' to my group members' daunting reality. This task took me into their neighborhoods, homes and lives. I was able gain understanding and empathy that I would have missed without this outreach component. I was also able to empathize with some of the frustration the Child Protection workers experienced in attempting to deal with the behaviors of addicted clients.

Eventually, eight women gave their commitment to attend the group. I decided to go ahead without further delay. When the group sessions actually started, only six of the eight women attended, however these six completed the group.

Both the referral and the intake process took far more time and energy than had been anticipated. The lack of response from the Child Protection workers was disappointing. It was difficult and sometimes impossible to connect with the woman and the Child Protection worker's at the same time (to define the expectations of the authorities). There was a clear reluctance on behalf of the Child Protection workers to 'name' the problem (substance misuse) or to define treatment expectations. Overall, this phase of the project was difficult and unrewarding, and it was challenging to maintain my own motivation.

g) DUAL RELATONSHIPS AND PROFESSIONAL BOUNDARIES

At the outset, I struggled with whether to disclose my own history of addictions. I had concerns about the size of the local recovery community (small) of which I was an active member and the consequent likelihood of running into a group participant at a 12 Step meeting. I was concerned for the maintenance and privacy of my own support network. As well, I worried that my presence at a meeting might inhibit or prevent a group member from attending. In Prince George, it was not uncommon to meet people at a meeting that I had met before in my capacity as Social Worker. Reaction ranges from a former client leaving the meeting; to other clients asking me to 'sponsor' them through the program (they already see me as a helper).

Charlotte Chapman (1997) defines a relationship as "ongoing contact that is planned in contrast to social contact that occurs accidentally" (p.74). Therefore, meeting women in the AA community was not problematic, but intentional socialization with clients would be. She also defines fundamental issues specific to AOD treatment that affect professionals. These include "self-disclosure, relationships in recovery, identification with client populations, and clients entering the substance abuse field" (p.77). While the use of self-disclosure can be therapeutic, it does change the focus from the client to the worker, which may diffuse the established professional boundary. As a feminist social worker, I am interested in balancing the power in relationships and in trying to work without the hierarchy that is inherent in a professional/client relationship. However, with each client, I need to be honest and clear about the 'power' that I do hold over their lives - as an employee of the Ministry for Children and Families

As a feminist, I subscribed to the principle that the helper must be open about their beliefs. As AA is such an integral part of my life, and I believed it to be a major resource in recovering from an addiction, I felt compelled to disclose my bias and my participation to the group. Trust levels would certainly have suffered if I were to unexpectedly meet a member later in a support group setting

h) INFORMED CONSENT

To ensure that all of the necessary protocols concerning guidelines for professional conduct, client rights and entitlements were addressed and presented to each group participant, the Changes and Choices Consent Form was developed. (Appendix III) When presenting this form to the participants during the individual orientation sessions, I asked

the women to read along with me as we covered each item in the form. Any questions or clarifications were addressed on an item by item basis.

i) THEORY OF EVALUATION METHODOLOGY

Prochasca and Di Clemente (1992) constructed a transtheroetical model of how people change. This model offers an integrative view on the structure of intentional change, either self-initiated or with psychotherapy. Their research was extensive, utilizing thousands of research participants, both women and men, who were attempting to alter addictive behaviors. They concluded that change occurred in a "cyclical pattern of movement through specific stages of change" (p. 1110). Therefore, specific treatment efforts should be targeted at the particular stage the person was in.

These researchers found five stages of change: precontemplation; contemplation; preparation; action and maintenance. To move through these stages, an addicted person must experience certain stage specific processes, which the authors contend are necessary to the completion of each stage, and the consequent moving on to the next. These include respectively: consciousness raising and environmental reevaluation, self-reevaluation, self-liberation, reinforcement management, helping relationships and stimulus control. (Prochaska, DiClemente & Norcross, 1992, p. 1109)

Following this research, Miller and Tonnigan (1995) developed a quantitative measure called the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). SOCRATES is an uncomplicated paper and pencil test designed to identify which stage in the change process a substance abuser is in. The SOCRATES test generates numerical scores in the measurement of three discrete categories:

- Recognition
- Ambivalence
- Taking Steps

Once the stage has been determined, a match can be made to a specific type of intervention to best address the needs of that particular stage. For instance, if person scores low in Recognition, then they may be considered to be at the pre-contemplative or contemplative stage and will need more information or education before they are ready to take action. Consequently, the creators of the scale would recommend that the intervention process focus on 'consciousness raising' and 'environmental reevaluation'.

For this Practicum, I chose this tool to address my initial goal of evaluating the outcome of the intervention. The test was to be used initially as a baseline measure of the women's recognition of substance abuse issues in their lives, and then applied again at the conclusion of the group process. "Changes in SOCRATES scores could reflect the impact of an intervention on problem recognition, ambivalence, and taking steps towards change" (Miller & Tonnigan, 1996, p. 81). I hoped that this pre-post test would be an indicator of the efficacy of the group intervention. I was also attracted to the cyclical processes of change that the tool was based on, as theoretically it provided a model for viewing relapse as normative rather than as failure. This concept was consistent with the cyclical nature of interactions in systems theory and the feminist notion of rebalancing perceptions of normality and deviance. (Land, 1995) Once the consent forms were completed, I conducted an initial interview with each candidate in her home. The SOCRATES test was then presented to the potential participant or if circumstances did not permit, it was left with the candidate to be completed later.

As there was an intrinsic element of coercion in the process, in that change was demanded by an authority figure, I think that the relevance of the scores was skewed. Seven women completed the SOCRATES, with only one missed item on all seven tests. At first, I was perplexed by the following scores, which appeared to be contradictory.

SOCRATES - Test Scores (maximum possible score)

Participant	Recognition (35)	Ambivalence(20)	Taking Steps(40)
# 1	26	9	38
# 2	18	13	33
# 3	30	17	40
# 4	33	17	40
# 5	33	14	36
# 6	15	15	34
# 7	19	14	36

For instance, #7 scores 19 out of a possible 35 on Recognition, yet reports 36 out of 40 on Taking Steps. Numbers #1, #2 and #6 also scored much lower on Recognition than on Taking Steps.

Numbers #3, #4 and #5 seem to be more congruent with high scores on both Recognition and Taking Steps. Interestingly, these were the only three women who had been to residential treatment, which may have helped in the area of Recognition. Except abstinence, none of the women could identify any concrete steps that they had taken to change their using behaviors. Regardless, they all scored high in this area. This may explain the scores on the Ambivalence scale, which I thought should be close to 0 if Recognition was moderate. It may also denote how powerful MCF intervention is in demanding compliance, or the illusion of compliance.

If a person is aware that their performance is being assessed, the measure is said to be *obtrusive.* (Kazdin, 1992). Obviously, this test is an obtrusive measure, especially in this application and as such, it is subject to threats to external validity such as reactivity. Measures are considered to be reactive when awareness of the assessment may lead to atypical responses. The identified 'double bind' may have increased the reactivity of this test and distorted the scores. For example, a mom who states that she is taking steps to change her drinking behavior may be influenced by the fear of loosing her children and will therefore utilize her knowledge of the 'right' answer, rather than the 'true' one.

Another possible reason for the apparently skewed scores could be that the SOCRATES test was developed and tested on a sample of individuals presenting for clinical treatment, which **Miller and Tonnigan (1996)** indicate would not be representative of a general population (p.87). It may be that the group of women studied here was not comparable to the clinical sample due to the fact that they were definitely NOT voluntarily presenting for treatment. These women may be reporting changes in lifestyle (taking steps) while still not admitting, recognizing or accepting that there is a problem (recognition) due to coercion.

A further tool, the Allen Barriers to Treatment Instrument, (ABTI, Appendix VIII) was also to be applied at the beginning of the group process. It purpose was to help in identifying and defining the barriers that exist for *these* women, in *this* community and to help plan to overcome these obstacles (Allen, 1996). This test was longer, more complex and apparently more difficult to understand, as the first three women it was presented to were unable to complete it. I did not try to present it to the other candidates at this time.

Instead, I decided to use this test collaboratively throughout the group process to help identify barriers and obstacles as they arose.

Allen's Barriers to Treatment Instrument identifies three categories of barriers:

1. treatment program characteristics
2. personal beliefs, feelings or thoughts
3. issues.

The first category on treatment program characteristics includes concrete issues that I endeavored to address in this Practicum. The first item in this category was *not knowing the location of treatment.* This aspect of the intervention was addressed by introducing group members to the institutions and self help programs that were available for them in the community and by having alcohol and drug counselors come to the group. Another of the items listed was *'having to talk to a male counselor'* and initially the group was able to request and receive services from a female counselor, as well as having a consistent counselor for all of the women. *The distance of treatment from home* was listed as a barrier and as mentioned previously, the group was held in the community in which the majority of the women lived. Having *no available transportation* was an item often cited by the women in Allen's study and I addressed this by providing transportation, having a taxi or myself pick them up. As the group was female only, the fear of *having to talk in groups where men are present* was not an issue. The final item on the scale was *no help staying drug and alcohol free after,* which was addressed by the introduction to, and attendance at self-help groups and by connecting group members with an alcohol and drug counselor. However, the concrete resources needed to get to meetings (bus pass) and have childcare provided (day care) were still unavailable from the Ministry at the end of the group process. These issues/barriers to maintaining a substance free lifestyle will be reviewed later in more detail.

Fortunately, I was able to access funds for the day care needs of the group through the community house. The transportation funds were accessed through the MCF allotment on each woman's files. Without these supports, attendance would certainly have suffered.

6) The Group Process

A) FACILITATOR'S STANCE

I began the group process by introducing myself as a social worker, a mother and an addict who was in the maintenance stage of her recovery and an MSW candidate. I told the women that as I spoke and presented material, I would use the term 'we' when referring to women's addictions and their sources and effects.

The following perspective was adopted as a starting point:

> "The lives of pregnant women and women with children are intimately entwined with multiple individual and 'systems' relationships that may include social agencies, hospitals, courts and schools, among others. Some of these relationships are healthy but many are destructive and dysfunctional. Without recognizing the importance of these relationships and encompassing them within the treatment program, we are taking an extremely limited approach to women's growth and development ... Treatment providers should help the chemically dependent woman to examine past relationships, including issues of loss, violence and incest; to validate and build upon her relational skills and needs; to learn how to parent successfully; and to let go of problematic, abusive relationships" (Finkelstein, 1996, p.28).

I further refined the facilitator's lens through the use and integration of feminist principles. I did this by using the following Meyers-Avis techniques:

> (1) talking about gender issues during therapy (money, power, child care, housework, the division of labor, etc.); being direct about the social worker's own beliefs; (2) re-labeling deviance and redefining normality so as to highlight women's strengths; (3) using Bowenian family systems theory to aid women in defining themselves independently of what others expect them to be; (4) focusing on the needs of women as individuals as well as on the needs of the relationship (Myers Avis, 1986, p220).

In this instance, item (4) would predominately address the mother/child relationship. Additionally, I saw my task was to encompass helping other helpers (Child Protection workers) to see the client as a woman with needs and entitlements of her own, as well as in her role of mother.

B) BEGINNING STAGE

For the initial opening and introductory portions of this first session, I intended to take the group through the following elements of the group process:

- Participant introductions

- Collaboratively set the ground rules
- Introduce the proposed schedule of group topics
- Hand out the group binders that held the 'Personal Action Plans'
- Explain the motif on the cover
- Introduce the concept of rituals to the group
- Clarify group and personal goals
- Review and clarify my role in relation to MCF

I began the group process with an exercise taken from the recently created manual for women's day treatment that had been developed by the Alcohol and Drug Services Provincial Women's Committee; the Days, Evenings and Weekends (DEW) program. The manual is gender specific and relevant to the needs of women. The exercise was presented as straightforward in the manual but it does *not* suggest what to do in the case of non-compliance! Four of the five women declined to participate. Only one of the woman wrote a single question before she noticed the others were declining to participate. Feeling defeated, I grabbed one of the tiny children's chairs that was handy and sat backwards on it, and put my head in my hands for a few moments. I raised my head and queried "What's goin' on here?" This empty, silent moment had created the needed space that, coupled with my apparent vulnerability and radical change in demeanor, empowered the angriest of the women to speak up. The proverbial dam burst. She began to vent her anger at the intrusiveness of the Child Welfare Authorities in her life. She spoke of feelings of horror (paranoia) at being constantly watched and scrutinized and the fear of loosing her daughter. She reached the point of tears, and at this point the other women began to support her and affirm her feelings and fears. As her venting diminished, the other women told their own stories of fear and loathing of the Ministry. The crisis of the intervention was now explicit. Some blamed the people they alleged had reported them to MCF. Several insisted that they were innocent of the 'charges'. I did not challenge this but rather embraced it as a place to begin. I reframed their sentiments, positioning them as a consequence of other people defining their problems and dictating solutions for them. I then stated that the role of our group was to help them define their own struggles and determine what they would need to begin to resolve them.

Other opportunities for reframing developed as a result of their venting. For example, one woman stated that her troubles were the result of a 'nosy' neighbor who

would call MCF at the least noise or disturbance which were frequent given that she and her daughter had a screaming match every morning over getting off to school. This was a place where she felt safe to begin and I reframed it as an example of the positive outcomes that could result from her participation in the group. If the reality was multiple investigations (this was her 9th), then the group process could be time spent establishing credibility with MCF through her consistent attendance and contact. It could also assist in accessing help for her and her daughter's interactions that resulted in screaming.

Some of the women felt that they *had* fulfilled the expectations of the Child Protection worker only to have a new worker assigned to them and to have to start the process all over again. The new worker would have no record of any previous efforts to amend the situation, such as parenting classes completed or participation in groups for spousal abuse. I agreed that this was a real and definite shortcoming of MCF and that the documentation of their efforts and positive outcomes would be a part of the collaborative work we would do.

I wanted to ensure that I did not triangulate, by aligning with the group against the Child Protection workers (an occurrence that I had found to be only too common amongst the contracted treatment agencies). Yet, I did want the group to benefit from the cohesion and identification that came as a result of their individual but similar experiences of oppression within the bureaucracy. Most of these women had faced multiple investigations with no apparent closure or ending to the process. They reported a process that was cloaked with secrecy, suspicion and unpredictability. The frequent changes in workers were often unannounced and always compulsory. Group members all spoke of worker relationships that were focused only on sanctioning, never on support. At this early stage in the group, I allowed this venting process and chose not challenge this 'blaming' dynamic. Instead, I prioritized the establishing and building of trust, credibility and empathy as the principle focus.

Part of the women's difficulty was rooted in their inability to distinguish between the different roles of different workers. The use of the generic term 'social worker' was used to describe social workers, Child Protection workers, financial aid workers, support workers, etc., with little appreciation of, or understanding for, the differing roles and responsibilities. I recognized that a challenging part of my task would be to help the group learn to sort through the seeming maze of bureaucracy. This process would hopefully provide an

awareness of the constraints and pressures that Child Protection workers were under and of their specific roles.

Many themes emerged from this first group session. The intrusiveness of the investigations and the ineffectiveness of the 'cat and mouse game' became glaringly apparent. These women felt vulnerable and perceived they had no power; consequently they were operating under an external locus of control. With this perceived and believed lack of power, they had become reduced to 'hiding' their lifestyles. Without a working relationship, the Child Protection worker's only option was to 'catch' them. Individually they were impoverished and as a group they were under-served and under-resourced in the community. Their experience with professional relationships was primarily punitive, resulting in feelings of fear, loss and abandonment, often a mirror of their intimate relationships and family histories. As a result, external family boundaries had become rigid and closed to outside help. They appeared to have developed coping mechanisms of denial, rationalization and blaming. These dynamics would prove to be both a challenge and opportunity that would need to be addressed in the group process.

In their discussion on the beginning stage of groups, Toseland and Rivas (1984) identify the importance of acknowledging the ambivalence most group members' feel about changing their behavior. These authors suggest that frank discussion will allow members to see that ambivalence is a common reaction to planned change. It seems likely that ambivalence is heightened when the change demand comes from an external source.

The agenda that I had set out for the group that first morning had not been completed. Instead, previously unidentified issues pivotal to the group's success had been identified and incorporated into the group process. These barriers to trust and consequent meaningful process would need to be resolved before we could proceed. In apparent validation of the process adopted for the first session, subsequent group sessions had full attendance. This provided an opportunity to re-introduce the inaugural day's agenda that was eventually covered off over the next few sessions.

B-1) Structure and Ritual

These subsequent sessions were to follow a structured and ritualized format. This was introduced to the participants at the beginning of the second session. This 'ritualization' involved the lighting of candles, playing a song from music that I thought to be inspiring

and a short reading from literature on women's recovery. Then each person could comment on the reading and/or their activities since the last session. Over a period of two sessions, I noticed that there was a level of agitation and stress during this supposed relaxing and centering time. I questioned the group as to whether they would like to remove a part or all of the opening process. They stated that they liked the candles and music and did not want to change that, and in fact they were responding to my request that they bring their own music that they felt was meaningful. I was still aware of an initial tension and decided to try a quick 'check-in' round first. During this time, each member could speak about how their lives had been between sessions and if there were any issues that were pressing. During this 'check in' time, the women often related incidents of personal crisis. For example, one woman was evicted from her home over the weekend. Often women reported that partners had moved in or out, children were suspended from school, or utilities were about to be cut off that day. One day a suicide attempt was related during this time and its discussion consumed the bulk of the morning. This new format worked quite well and after venting the women were able to attend to the music and reading and relate their own difficult situations and issues to the messages found in the ritual.

B-2) Attendance

Non-attendance was to be phoned in early enough to cancel the transportation and daycare services. After a while the women began to worry about each other if they had not come to a session. I would try to help them express what fears they had if someone did not show up and to speak openly about their assumptions about where the missing member was, or what had prevented their coming to group. Later in the process, I was able to relate the group experience of concern to help them understand and appreciate the family perspective.

Our youngest member insisted that she just couldn't wake up in the morning; she gave me permission to walk over and wake her if she slept in. She was less than a block away but had no phone. By the later stages of the group the first arrival for the session would run over to her home and wake her up! She would bundle her infant up and come for her first coffee of the day. When we went to wake her, it was evident that she was not using the intravenous drugs that were her 'habit', as she and the baby were healthy and well fed and at home in a clean, quiet apartment. A mainstream treatment facility may not have

had the supports needed for this young mom and while the reports to the Child Protection worker may indicate resistance or a lack of commitment, neither would be accurate or describe the dynamic realistically. She just could not yet get out of bed on her own. Once awakened she participated fully, did the homework assigned and contributed to the group by bringing books and music.

Enabling has a very bad name in the field of substance misuse but was often a necessary social work role for me to assume if I was to be of help to these women. It was not enough to assess their level of motivation as being "inadequate". These moms appeared to be in need of parenting and nurturing themselves. They seemed to see the 'enabling' as a sign of genuine caring. When women did not show up, I would continue to try to contact them in the interim and let them know they were missed, so they would not want to hide from the group. As we were a small group, it was more enjoyable and productive when we had full attendance.

B-3) Developing Trust

Trust is an essential component of small group dynamics. A trust-based group dynamic may contain the following elements: consistency, caring, compassion, commitment and comfort. I believed that the presence of these themes would allow the growth of emotional security within the group and I sought opportunities to foster these. To this end, I cautioned the women to consider to what extent they were comfortable with disclosure, both with me and with each other. We agreed that I would report only attendance and participation to the protection workers. Any relapses or using episodes would not be reported by me unless a child was hurt or at risk, as per the mandatory reporting laws. However, I advised them that it was only their commitment to each other that would ensure confidentiality between the group members, and that trusting each other may take awhile.

After several sessions of not reporting substance misuse, they began to trust the process and each other enough to openly share their 'slips'. We would then try to track what precipitated or motivated the episode and examine the costs and benefits that occurred as a result of using. I encouraged other members to provide feedback, and to share their own similar experiences. When a woman spoke of using a drug that was not familiar to the others, I tried to identify the feelings around the incident that could be generalized to all

substance misuse. The technique of *universalizing* helped make unique experiences interesting to all members of the group (Toseland & Rivas, 1984).

One woman was at a stage in her recovery where she spoke freely of the power of her cocaine addiction and of her fear that she would use again. She had requested another session (3 weeks) in residential treatment from her worker three months after her first treatment program, as she did not feel safe in her environment with all of the 'triggers' to use. The CPW had responded in a way that she felt that her struggles were trivialized. She told the group of her anger, frustration and shame that her addiction compelled that she ask for help from someone so cold and foreign to her.

This woman became a great resource for the group; as an admitted addict I was able to give her the esteem due an 'expert' in the areas of what worked and what didn't in trying to stay straight. I learned that she would be six months 'clean' on a date that we had a group session scheduled. At this session, I took a moment to make a short speech to the group about her 'birthday' and presented her with a women's recovery book and a birthday card as is done in many 12 Step Programs to recognize such milestones. The other women spoke of their envy at such a long time clean and began to consider when they would be eligible for a six-month celebration. This was the first mention of 'dry dates' and resulted in open discussion and support when someone relapsed and 'lost' their time sober. The behavior modification techniques used by 12 step groups such as a public presentation of medallions for periods of sobriety also provides ritual and positive affirmations of efforts made.

C) WORKING STAGE OF THE GROUP

C-1) Content

Appendix- IV - delineates the course content that I was to facilitate during each group session. Conceptually, I had broken down the anticipated group process into the three phases: beginning, middle and ending stages. As the process unfolded, I found that I had been optimistic about the amount of information that I would be able to effectively present to the group during the eight weeks. I had not allocated sufficient time for the group members to process and come to terms with two fundamental issues:

1. The initial trauma that had resulted from an outside agency (MCF) defining their problem for them and the attendant threats to their family system;

2. The length of time that would be needed for the women to develop enough trust to acknowledge that substances were in fact pivotal to the many problems in their lives.

The group members continued to be inhibited and had to repeatedly overcome the previously cited double bind that prevented candid disclosure. These realities slowed the group's progress through the planned course materials.

C-2) Guidelines

Wherever possible, we defined the group guidelines and the days' process together to ensure that the participants felt connection to the group. Having worked collaboratively on the guidelines allowed me to encourage the women to challenge each other on the issues that they had tabled. I presented the guidelines as both adaptable and flexible, and encouraged the women to express their concerns if they felt they were not working for them. As situations arose, we also added to the guidelines, examples being the prohibition of lengthy story telling about others and the discouragement of advice giving.

C-3) Gender and Power Issues

Several of the early sessions were spent examining the impact of gender on women's lives and their addictions. We began by deconstructing the power and status hierarchy that is inherent in patriarchy. I did not use this language but rather allowed the women to brainstorm on these subjects and examine the differing role expectations for women and men and how this related to substance abuse. Themes for these sessions included: stereotyping that results in the stigmatization of substance abusing women; the lack of status of women in society and the consequent desire to align with men; the construction of gender and the internalizing of woman/mother blaming.

For instance, one woman described her fathers' violence as a result of his shame at having an alcoholic wife, while stating that his drinking was a response to having to work so hard. Although she had numerous siblings and an impoverished farm family, she did not perceive her mother to be working. She was quite brutal in describing the shame of her mother's drinking and how it damaged her childhood. This 'mother blaming' needed to be addressed or this group of addicted women would further internalize it. I encouraged them to examine family dynamics in the light of power and choice. I also expressed respect for the labor required in women's caring and placed value on unpaid labor.

We next took gender to another level where group members identified the possible sources of the construction of gender, i.e. - church, family, patriarchy, government, media, etc. and an examination of the power structures that benefit from these rigid roles. I also endeavored to link gender constructions to women's sexual expressions, freedoms and constraints, as many of their comments had convinced me that sexuality was a shameful issue for the group.

Through discussion and statistics we examined the 'feminization' of poverty. This was a subject close to their hearts and they seemed to be empowered by realizations that their inadequate finances were not fully attributable to individual shortcomings, but rather that many forces were at play in influencing their socioeconomic status.

We used simple genograms and eco-maps to examine family patterns. The genograms helped to show family influences and intergenerational transmissions of addictions and patterns of violence. The family maps also helped to illustrate the connections and disconnections in their lives. We were then able to explore the over-functioning and under-functioning patterns in their current and past relationships. Consideration was given to the weight of responsibility that they each carried and how this added to their need to 'get away' that often resulted in their using. The two women whose partners were now the primary caregivers (when the women were using) were able to identify the resentment that they had for having carried the entire load in the past. They felt that they were due this 'break' from responsibility and it also helped them to justify their 'bingeing'.

The environmental context in which the woman functioned also needed to be examined. The eco-maps graphically indicated the outward flow of energy from the women to most of their relationships. Their stressful interactions with most institutions, such as banks, financial aid offices, MCF and schools were illustrated through the maps. Overall, there was a glaring lack of positive support or interactions in their lives.

Many of the women were accused of being disloyal and judgmental by their family members because their efforts to change required that firmer boundaries be set between the family of origin and their family of creation. The implicit message in the accusations of 'not caring or not loving' was very powerful, as the women had internalized gender role expectations that required them to care in order to be 'good', regardless of the cost to themselves. By educating the women about this pressure, which can be so overwhelming, they had a chance not to react and merge back into the old system dynamic.

Bowenian family systems theory posits that it is not a solution to cut-off emotionally from ones family of origin, as the dysfunctional patterns that have developed will resurface in new relationships. Consequently, I did not promote distancing from addicted family members as a long-term goal. Rather, I cautioned the women to be aware of the potential for "change back" messages from their close family members. I also stated that it might be necessary distance themselves from certain relationships until they had gained stability in their change efforts. The women were then able to express the pressures that came from their partners or boyfriends to continue to drink or use, and talk about the desire to drink to be a 'part of' with their families. One woman stated she could not dance sober, and another could not have sex without being high. Clearly, substances were functioning as a 'social lubricant', and these women had become dependant on substances to fulfill certain basic needs such as the need to belong.

C-4) Multi-Service Team

The beginning stage of the group process had included the identification of long and short-term goals. In the working stage, the potential barriers to the achievement of these goals emerged and were discussed. Unhealthy family interactions, past abuses and difficulties with the demands of parenting were commonly identified factors that were exposed through the group process as 'triggers' for relapse behaviors. Finkelstein (1996) recommends that treatment providers must address these underlying issues of concern concurrently with treating women's' addictions. Due to the time restraints of the group, it was necessary to refer women to specific supports in these areas.

As previously cited, Annette Dowling, the Practicum supervisor, was piloting a multi-service team project for MCF. The team included a counselor from a family service agency that provided individual and group parenting courses, an MSW for individual, child, couple or family therapy and an alcohol and drug counselor. This team attended a group session and agreed to provide services to these women on an ongoing basis at the community house. This team intervention would provide immediate support in the areas previously noted, and the responsiveness of the team was heartening.

This process was very empowering for the women as the team was sensitive and caring. They deferred to the women for seating arrangements and emphasized that they were the visitors and that the women the resident experts. The women were encouraged by this resource opportunity. They were also relieved that the services that they would need to

address the issues that they had identified in their Personal Action Plans would be coordinated. This meant that they would not have to worry about getting to three different appointments each week, as the team would travel to the Beech Community House. The women expressed a sense of accomplishment for developing their own treatment plans and for managing this process from a place that felt like home to them.

C-5) AA and NA Speakers

At two of the group sessions, speakers from 12 Step Programs came to speak to the group. The women who came were very powerful in the telling of their own stories. This allowed for the identification process to occur for the group members. Their stories were similar in the areas of personal relationships and parenting issues as well as their substance abuse histories. Group participants later spoke informally with these women and asked many questions, including one woman asking the speaker to sponsor her. She agreed to fulfill this role and they exchanged of phone numbers.

As an introduction to a resource which would be on going; I took the group to an AA meeting and then arranged for subsequent transportation, through volunteers from AA and NA, enabling group members to attend two additional meetings during the course of our group sessions. Left on their own, they did not attend during the time of our remaining group sessions. If they needed to contact a support group, they were now familiar with three different groups from first hand experience.

C-6) Group Functioning

Toseland and Rivas (1984) suggest that when assessing the whole group rather than the individuals in it, four major areas of group dynamics should be considered. "These include the group's (1) communication and interaction patterns, (2) attraction, (3) social controls, and (4) culture" (p. 174).

Evidence of the growth in the group communication patterns in this stage included:

- a higher incidence of member-to-member interaction and less communication being channeled through me;
- more important and in-depth disclosures about substance abuse issues;
- members ability to challenge and support each other;
- the ability for members to draw each other out if they were withdrawn.

Evidence of the attraction of the group included:

- Regular attendance and no attrition after the first session
- members exchanging phone numbers;
- growing commitment to personal and group goals;
- members giving gifts of clothing and other concrete goods;
- members coming early and staying for other activities after the session;
- Members speaking of themselves as a group to others, using 'we' language.

Evidence of the development of norms, roles and status hierarchies that comprise the social control component included:

- members assuming leadership and gaining status through staying clean;
- older members assuming parental concerns regarding younger members and their infants;
- Younger members accepting the concern of older members.

Evidence that the group was developing a culture was indicated through:

- movement from individual members isolating and hiding from the Child Welfare workers to the group as a whole feeling empowered to develop working relationships with MCF as a system and with their individual workers;
- Movement from anger and hostility against the system as the only commonality to shared goals and aspirations such as returning to school.
- their pride at their ability to reciprocally contribute to each other and to the house's resources;
- Members' vocalizing a more positive and less blaming attitude towards women.

D) TERMINATION STAGE

The termination stage of the group process was planned for and integrated into the group consciousness from the beginning. Members were aware of the end date for the group and were also asked to participate in the collaborative planning of how we would celebrate our ending. Toseland and Rivas (1984) note the need to plan for the future and to make referrals at this final stage of group process. Anxiety was minimal in this case, as the connections to the needed counseling and treatment had already been made. The women knew that they would continue to see each other at the community house for parenting classes and alcohol and drug counseling. This ongoing plan for services in a familiar setting with people who they already knew eased the final transition of the group.

Toseland and Rivas (1984) identify that a common ending for groups is getting together for dinner. They state that many of the tasks of ending a group can be accomplished at this time. This group decided to attend an AA dinner and dance as the ending celebration. To begin the evening, I awarded each woman with a framed certificate of completion. They all expressed pride at having completed the group, and the woman whose home we met in immediately hung hers in the living room. Spirits were high, and the women spoke of amazement of having 'made it' and the changes in their perceptions since the beginning of the group. Later, the dinner provided further time to discuss feelings about the group ending and to congratulate each other on the changes they saw in each other over the previous eight weeks. Some of the women made plans for ongoing contact with each other.

7) Evaluation of the Practicum

The original objective was to conceptualize, create and facilitate a psycho-educational group with this population. My assumption was that with support and consciousness raising in the area of addictions, the women would be able to self-identify their struggles with substances and create plans to resolve them. The following review reflects my evaluation of the level of accomplishment of the objectives as listed and a short rationale for each conclusion.

a) To review the current literature relating to women and addictions.

This objective was fulfilled and that I now have a broader knowledge base of the literature in the area of women and addictions. The information gathered through the genograms that the women drew confirmed much of the literature on the multigenerational transmission of substance abuse (Bepko, 1985: Bowen, 1972: Stanton, 1982; Steinglass, 1987). That shame and low self esteem exacerbated women's struggles with addictions was clear from the literature (Bepko & Krestan; 1985; Finkelstein, 1996; Schaef, 1992) and also reflected in the group experience.

b) *To identify gender specific needs and issues in substance abuse treatment.*

As a group we did identify gender specific needs and issues in substance abuse treatment. The literature review indicates many of the issues, and the ABTI helped to identify those that were relevant to this group in this community.

c) *To learn how to motivate and support women in a change effort..*

The objective to learn how to motivate and support women in a change effort was achieved. The women expressed their growth and learning in many ways. They gained strength in the recognition of their common concerns and mutual difficulties. They began about half way through the group to aspire to pursue education, work, and stability in their relationships. They achieved a new perspective on substance abuse and were willing to admit their addictions and accept help. This was fundamentally different than our starting point, when the only goal they expressed was getting the authorities out of their lives.

I found that to keep the group motivated, I needed to be flexible and attentive to the needs of these women, which entailed letting go of what and how I thought they needed to learn. For instance, I had intended to *present* material on issues such as the progression of addictions, violence in relationships, and family roles. When I began to 'lecture' or 'present' information, or worse yet try to show a film, I noticed a marked impatience with, and a lack of attention to, the information. I suspect that general information was too disconnected from their reality for them to be able to absorb it. However, if I provided the space and time to create collages on women and addictions, the art expressed a level of understanding and awareness of addictions and relationships that surprised me. Then I could let each woman describe the picture, and the others would be engrossed in this real life story that they were so closely related to. One woman cut and pasted eyes all over the top of her collage. She then explained that the eyes were MCF, with no hands to help, or ears to listen, but only eyes to spy on her. Clearly, these women were more motivated when the material was relevant and experiential.

d) To learn how to identify and remove barriers to women seeking treatment in the community of Prince George, British Columbia;

The group structure itself removed many of the barriers identified in the literature and on the ABTI (see Appendix VIII). The group process and the women's efforts

addressed barriers in the category of personal beliefs, feelings and thoughts: shame, trust, denial, and not believing in their ability to change.

As the group work progressed, barriers were identified and the ability to remove a barrier was also experienced as the group process unfolded. The responsiveness of the multi-service team removed several common systems barrier by providing multiple services to the mom and the children under one roof. Without this response, the referrals would have necessitated several appointments a week for parenting, drug and alcohol and counseling for identified issues. Also, without the response, the women would have increased struggles with childcare and transportation, complicated by the finding of and familiarizing with new agencies and offices. Many group mornings, none of the members had bus fare, and therefore would not have been able to attend without the transportation provided. Further, the lack of telephones would impair their ability to cancel the appointments, and this could be misinterpreted as non-compliance or a lack of commitment.

e) To gain skill working collaboratively with women and the Child Welfare system with an aim of improving the relationship between them;

Many interactions in this undertaking provided opportunities to improve skills in facilitating collaboration between these empowered participants and the Child Welfare system. The women were unable to distinguish the particular roles of the service providers in their lives: the financial aid workers, Child Protection workers, counselors, homemakers and child care workers. This resulted in role confusion, which created conflict and tension. Their expectation of the Child Protection workers role was supportive counseling and the provision of resources, both necessary roles, but not those that the Child Protection workers have the luxury of fulfilling. The role demanded of MCF Child Protection workers is restrictive to many social workers, many of whom have identified a yearning to be able to work with clients, rather than merely 'policing', 'enforcing' and 'brokering services'.

The final session was a learning experience for all of the professionals present. The Child Protection workers, whom we all thought would have the necessary funds for bus passes, had been instructed by MCF management that they could no longer provide transportation funding. Once this was known, it relieved the blaming of individual workers for not providing support: they had no access themselves.

I hoped that by demonstrating the genuine need of the participants in conjunction with highlighting the immensity of the pressure and expectations that were entailed in stopping the substance misuse, we could gain both respect and support for their need. Individual workers reacted differently. One responded defensively to her client's description of the aid that was needed but not previously received. Most of the workers empathized with the enormity of change had been tabled *by these women*, in itself a major achievement for the participants. Regardless of the system's inability to resolve these resource issues at this meeting, the women were empowered by the group process and felt that they had been able to state their cases and to be heard.

f) To gain experience in evaluating the outcome of change efforts;

As previously stated, the second application of the SOCRATES scale did not yield any significant indications of change. This finding is not believed to be an indicator of the efficacy of the intervention process but rather is due to the previously cited factors that I believe skewed the test and limited it's relevance to this specific population.

At the last scheduled group session the group participants were provided with an evaluation questionnaire (Appendix VII). The participants were asked to place the finished form in an envelope and return it to Annette Dowling, the on site Practicum supervisor. It was explained to them that this procedure was being used to ensure their anonymity. The women were encouraged to answer honestly so that I could evaluate my practice and make future efforts more responsive to client needs. The following summarizes the information that was compiled by Annette Dowling. The ranges of responses available were: *very poor*, *poor*, *average*, *good* and *excellent.*

All of the participants gave the community house, the childcare and the provided transportation, *excellent* ratings. The group size was rated as *average* to *good*, perhaps reflecting an ongoing anxiety that we would not have enough participants to continue. Responses to the candles and music ranged from *average* to *excellent*, with a special comment: "Makes you feel at home".

The question, on the days that the group was held, was given an *excellent* rating by all. One participant noted that the group being Friday and Monday mornings provided support around the weekends. Eight weeks of group meetings received a rating from *poor* to *excellent*, with four individuals commenting on the need for the group to be longer. The participants

rated the time for discussion from *good* to *excellent* and one stated that "It could have been longer". The participants gave the check-in process a range of *good* to *excellent* and included the following statements on the process. "Getting things out and not trapped in", "May have needed more time to spend at times". The indications that the time allotted for group process was inadequate I viewed as positive affirmation for the group, particularly considering that initially they were involuntary participants.

All but one of the respondents gave an *excellent* rating to the group being gender specific. The *poor* rating included the comment "Wouldn't mind experiencing men's point of view". The participants gave the sessions on gender issues *good* to *excellent* ratings, with the following comment: "Gender is usually the main problem". The women gave an *excellent* rating to the sessions on shame, stigma and family issues.

The participants gave the speakers from the AA and NA community a *good* to *excellent* rating. The handouts, the time to be creative and the workshop on relationships received *good* to *excellent* ratings.

Question 15, regarding the communication with the Ministry workers elicited a range of responses from *poor* to *excellent*, denoting the unclear structure of the question. Comments such as "I still haven't met my social worker", "Communication with others has been good", "At least get an output.. (illegible) ...our needs and support" indicate that the statement resulted in different interpretations.

Open ended questions revealed that participants felt the best part was "meeting women", "sharing experiences", support", "have problems similar to other people", "talk and vent". Participants were reluctant to respond to the question on the worst part of the group experience and described the group as a good, positive experience. The one exception was a participant expressing concern about how the group was introduced - she stated "I felt pushed, asking is so much nicer and you feel like it is your own choice".

Comments that reflected an increased understanding about their substance misuse included "It has definitely opened my mind and made me think", "I didn't think I had a problem to begin with, but it was good to broaden the issue". The women were positive about the effect they felt the group had on their lives. They noted the support and the changes in thinking about whether substance misuse was an issue in their life. One stated "It had an excellent effect. I think more women should have went through this". The participants' comments indicated that the group had a profound effect on some of the

changes in their life. For example, "It made me feel like getting ahead in life, with getting a career and more self esteem has come about because of this group", "helped me with short and long term goals", "There were feelings in there, Knowing that they really care".

The responses were positive about the support, bonding and friendship built during the group. One woman acknowledged the growth of this relationship, stating "Not at first. A trust had to be found. Now I am sad to say goodbye but we exchanged phone numbers".

The women gave an *excellent* rating regarding their opportunity to be heard commenting "Someone is actually listening to me!" "I don't always like to talk in front of a group, she'd always find time to listen". Experience with me as the group facilitator and whether I listened to them was rated *excellent* by all with special comments: "Very supportive", "She always made time and more time for me", "She was caring and interested in what you had to say, whereas the other workers didn't care". They rated my ability to understand them as *good* to *excellent*, commenting: "My facilitator understood, or tried to understand and took the time to understand", "The bond was there between women to understand women". The open ended question relating to my knowledge on the subject of addictions garnered: "Knowing it takes one to know one", "Knowing she's been there, done that and won't go there again. What I want." "She was very helpful towards my goals". The ambiguity of the question on what facilitator could have done differently to be more helpful resulted in an *excellent* rating by two participants and no rating by the others. Comments were also vague, including "Unsure but this group is just getting off the ground", "Unsure" and "Very helpful".

All participants concluded the questionnaire by submitting an overall rating of *excellent* both for the group and for the facilitator. This *excellent* rating, from a participant population with a historically negative relationship to any MCF related resource is gratifying for the facilitator. However, this rating may also reflect the absence of any available supportive resources for substance misusing women at this critical early stage in the process of change.

8) Conclusions of the Practicum

Facilitating this group experience resulted in the evolution of the following conclusions.

a) Women who misuse substances are often labeled resistant but they *can* be engaged in a change process by social workers with a genuine respect and admiration for them. Initially, this can be difficult and taxing work. It is resource intensive in the beginning but it is a preventative and proactive practice that supports women and protects children, thereby negating the need for high cost foster care. Seeing the children twice a week relieved concerns for their safety significantly.

b) I derived deep satisfaction observing the monumental changes that the women made. The growth of personal aspirations, to improve their quality of life, which evolved through the recognition of their choices and options, was inspiring, energizing and rewarding.

c) Communication between Child Protection workers and alcohol and drug workers is sporadic and inefficient. Reciprocal sharing of information that would be in the best interest of the children and family does not yet occur consistently due in part, to historical tensions and work overload. Thus, the macrosystem mirrors the family system and suffers from rigid boundaries that do not encourage or allow necessary input.

d) The relationships between Child Protection and AOD workers are inhibited by gaps in the knowledge of each other's roles and mandates, resulting in misunderstandings and interactions that are not functional.

e) The crisis that is created by the intervention provides an optimal condition for change but these women lack the resources necessary to support change efforts.

f) Referrals to services at the early stage of substance misuse identification are fragmented and difficult to access, particularly gender specific services. Women who are already impoverished and lacking supportive resources are expected to manage multiple appointments for themselves, their spouses and their children.

g) This population requires a high degree of contact, including outreach services, to support early recovery and assure the well being of the children. It is inadequate and

perhaps unethical for social workers to identify and confront women with addictions without follow up to ensure that the stress of the investigation has not exacerbated the addiction and created an even more dangerous situation.

h) Isolation is a common and serious problem in this population, often intensified by poor relationships with the authorities. When addicted women bond in a supportive group environment, the isolation is lessened. They gain power through supporting each other. They benefit from their similarity of family history and relational experiences, which helps to normalize their maladaptive responses to the disruptions in their lives. This allows the focus to move from individual pathology to the poor fit between women and their environment. The outcome of viewing the problem in this manner is a decrease in the shame and stigma attached to women with addictions; promoting the consequent diminishing of rationalizations and denial which allows problem identification to begin.

9) Personal Learning

This process taught me what the researchers were speaking about when they recommended that interventions needed to be grounded in women's experience (Finkelstein, Kennedy, Thomas & Kearns, 1998). It meant that they needed to be grounded in the experience of *these* women in *this* community with *these* relationships with service providers. This fit well with the social work value of uniqueness. Although addicted women share many commonalties with which I thought I was familiar, the environmental and cultural context of this group of primarily First Nations women, in this northern community, dealing with this system of Child Welfare that has evolved in this region, made them distinct.

The high percentage of First Nations' women in the MCF referral group speaks to the need for culturally competent service delivery. There is a need for empowerment strategies and processes to be used with these women who are oppressed in many ways. Connecting with one's heritage can be very empowering but was beyond the scope of this project.

The psycho-educational component was reciprocal. The women taught me what they needed at this point in their lives and my role was to search for information, solutions and options within the environment. My role clarified over the course of the group and my efforts were increasingly targeted at the 'goodness of fit' between the group members and their environments, with a goal of improving the interactions rather than 'fixing' the women or 'fixing' the system. While the participants had no formal notion of ecological concepts, these women helped to teach me to think ecologically! As I tried to shape their knowledge base, they shaped mine. As I tried to deal with their resistance, they forced me to look at my own and at the Child Welfare System's. I began to understand the transactional nature of resistance. My own resistance manifested in clinging to the notion that I knew best the solutions for their problems, which of course caused them to resist the imposition. The Child Welfare system had often labeled substance-abusing moms as resistant to looking at their problems, yet as a system we were resistant to naming the problem. This caused a lack of clarity in the interactions and resulted in vague 'demands for work' from the Child Protection workers, and misguided, ineffective responses from the women.

10) Recommendations for Social Work Practice

This project indicates the need for integrated case management practice with regular case conferences to coordinate and sequence the service needs of this population. Then, the woman, the social worker, other helpers, significant others and the family can all begin to define their own roles and take individual responsibility for their portion of the treatment dynamic. This would alleviate the pressure on Child Welfare workers to make important decisions about the safety of the children on their own. Change efforts would then be targeted at all levels: the environment, the institutions, the family, the individual women and the maladaptive transactions between each layer. A process that includes service providers sharing power and responsibility with women struggling with addictions helps to ensure that the women are invested in the change and have a sense of control in the process.

If the Child Protection worker only asks for information from the AOD worker, without defining the concerns that led to their request, it is easy to understand how the AOD worker would be reluctant to breach the confidential relationship with the client. Without the history that the Child Protection worker has, the AOD worker is reduced to trying to function without adequate information to generate a comprehensive assessment. Clearly, there exists an opportunity to improve on the level of the integration of services.

Social workers need to understand the dynamics of a non-voluntary change process, and provide adequate support at this crucial time. The crises that are common at this stage in recovery add additional stress to both the family and the Child Welfare system, and can result in continued dysfunctional adaptations if the environment does not provide the 'nutrients' that are necessary for the growth sought. Social workers need to understand that a lack of resources, in part, explains the inability of these women to comply with workers demands for change, and advocate for concrete supports within the agency.

A high level of contact throughout the process is a necessary component, both to build the relationships necessary for the social worker to become an agent of change, and to assess the safety of the children. When high caseloads do not allow the necessary time, it is essential that working relationships be developed with AOD workers to aid in the process.

Social workers need to respect the power of addictions. To do that, they need to understand the meaning that women ascribe to their relationship with the substance. The women in Akin and Gregoire's study described addictions as an "omnipotent, omnipresent force. Their relationship with drugs was the most powerful relationship they had experienced" (p.396). Social workers need to take time to develop a relationship with addicted women and *listen* to the stories of their lives. Then, we need to respect the enormity of the changes we are asking from women, and work diligently to find or create resources to support their efforts.

For many reasons, this is a difficult population to engage and service. The basic explanation is that these women are not consciously seeking or desiring change. It is being demanded, with a high cost for noncompliance. Therefore, the desire to change has to be inspired by communicating hope, respect, admiration and a belief in the ability of women to change. This takes time. Basic social work processes such as intake are excessively time-consuming with involuntary clients. It is unlikely that other service providers would 'chase'

the women for as long as I did to engage them in the process. However, it appears that the efforts were worthwhile, in light of the fact that the six women who started the group were committed throughout the process, and identified positive changes in the final evaluation.

11) Recommendations for Child Welfare Policy

Realistically, MCF has not granted the Child Protection workers the time, or the role freedom, to be able to do this important work. Child Welfare agencies would benefit from lowering the case loads to allow workers the time to engage these women in change. However, many people have recommended this many times, to no avail. Therefore, the Child Welfare system would benefit from the creation of designated outreach positions to engage, track, support and work collaboratively with this population in identifying treatment needs.

Other than the small budget of the Community Development Worker, there does not seem to be MCF funds readily available to support the concrete needs of transportation and childcare. While funds may exist, to attempt to access them requires debilitating and discouraging amounts of paper work for Child Protection workers and a lengthy wait for the requests to filter up through the system. This is ludicrously little expense in comparison to the cost of foster or institutional care for the thirteen children who were also involved in the process.

Both Child Welfare agencies and families affected by substance misuse are highly stressed systems to begin with, often with a dearth of resources or supports to handle the crisis of the investigation. While it is necessary to utilize what is available to ease the immediate distress, partial solutions can never be regarded as an adequate response to the demonstrated need that exists in both systems. Continued social action efforts must be undertaken to lobby for increased funding for MCF and to ensure equitable health care options for women.

Child Welfare agencies must understand that a referral alone is not adequate to address the enormous adaptation that is required by the woman and her family. Immediate and intensive efforts are needed to prevent the distancing and deceit that often occurs as a result of the investigation. Support needs to be ongoing, and to remain in place for an

extended period of time. The success at the community house indicates that programs need to be delivered in the communities where women live, in non-institutional, non-stigmatised settings that are familiar and comfortable to the population served. Tracking the attendance at, and goodness-of-fit of, treatment efforts is essential.

APPENDIX I

(Poster for the Community Home)

CHANGES & CHOICES

AN 8 WEEK MUTUAL AID GROUP PROCESS FOR

WOMEN

EXPLORING THE TIES THAT BIND US:

addictions; relationships; emotions; identity; gender; self-esteem

If this sounds interesting to you…

Complete the following and I'll get in touch with you soon! Thanks!

APPENDIX II
(Intake form)

CHANGES & CHOICES...

relationships identity gender addictions self esteem emotions

My first name is

_____

I am interested in the group and you can reach me at _____ _____

The best time for me to attend on Tuesday is _____

I need childcare for

_____

APPENDIX III

(Consent form)

CHANGES AND CHOICES!

RELEASE OF INFORMATION AGREEMENT

I, _____, understand that the group process I am agreeing to participate in is confidential within the limits of the (changing) law. I understand these exceptions:

1. If the group facilitator, Adele Kupp, has reason to believe that a child is being physically or sexually abused or in danger of being abused, she has a legal and ethical mandate to report this concern to the Ministry of Children and Families, (MCF). I understand that Adele Kupp will first consult with me, and that I will be given the choice of reporting the concern myself.
2. If the group facilitator has a reason to believe that I might injure myself or someone else, or that other persons are at risk for some other reasons, she has the legal and ethical right to intervene, even if this means breaking confidentiality.
3. It may be necessary for Adele, the group facilitator, to speak to other professionals involved in aspects of my physical and emotional health. Wherever possible, this will be done with my understanding the intent of such contact, and this sharing of information will be on a 'need to know' basis. I understand that I have the right to know what went on in these discussions.
4. My group facilitator, Adele Kupp, has explained to me that this group is being conducted as the Practicum component of her Masters of Social Work Program. As such, she will need to consult with, and be supervised by:

Eveline Millikin, Professor of Social Work, University of Manitoba.
Kathryn Levine, Professor of Social Work, University of Manitoba.
Annette Dowling, Supervisor Multidisciplinary Team, Prince George MCF.

5. I understand that at times, Adele may request to video tape her work in the group, and that I have the right to choose to participate in this process. I understand that only the 3 supervisors of her educational process, Eveline Millikin, Kathryn Levine and Annette Dowling will ever view the tapes and that the tapes will be destroyed after the supervisory team views them.

APPENDIX IV

(Programme outline)

CHANGES

&

CHOICES

GROUP MODULES

BREAKING FREE OF THE TIES THAT BIND

PROGRAM OUTLINE

WEEK # 1

Session 1 Introduction and orientation to participants and group process

Session 2 Addictions as a disease (presentation, exercise and discussion)

WEEK #2

Session 3 The Addictive Process, (presentation, exercise and discussion)

Session 4 The Family and The Addictive Process (film and discussion)

WEEK #3

Session 5 The Addictive Process and Being Female. Part 1 - gender issues

Session 6 Integrate with Personal Action Plan (discussion, workshop)

WEEK #4

Session 7 Part 2 - unique needs (discussion, exercise and journaling)

Session 8 Integrate with Personal Action Plan (discussion, workshop)

WEEK #5

Session 9 Part 3 - Family Roles - real & imagined (presentation & discussion)

Session 10 Integrate with personal Action Plan (discussion, workshop)

WEEK #6

Session 11 Part 4 - Money, Work - resource management (presentation, discuss)

Session 12 Integrate with Personal Action Plan (discussion, workshop)

WEEK #7

Session 13 Part 5 - Violence, Abuse - resources, solutions (presentation, discuss)

Session 14 Integrate with Personal Action Plans (discussion, workshop)

WEEK #8

Session 15 The Recovery Process - key elements (presentation, exercise)

Session 16 Review Personal Action Plans (group affirmation)

WEEK #9

Session 17 Course Graduation Ceremony

APPENDIX V

(letter to the Ministry)

Adele Kupp

#105 3307 Westwood Drive, Prince George BC, V2N 1S4
phone 564 - 3901 ~ e mail othersfollow@msn.com

March 5, 1998

Kim Chartrand,
Ministry of Children and Families
Westwood Drive
Prince George, BC
V2N 1S3

Re: AOD (Alcohol and Other Drug) Women's Group, Beech Crescent Community Home

Dear Kim ,
Further to our recent discussions this letter will serve to provide an outline of the eight week, AOD Women's Group that I will be facilitating at the Beech Crescent Community Home.
Participants in this group will be limited to a maximum of 10. As discussed, I would ask that your front line case managers review their portfolios and identify potential group participants based on the provided selection criteria and their evaluations of appropriate clients and their relevant case histories.

Selection Criteria:
1.Clients where alcohol or drugs (AOD) have been abused by the woman and have impacted adversely on family functioning causing the family to become a concern of the 'Ministry'.
2. Some previous efforts may have been made at achieving sobriety, or complying with the social worker's plan of action, but concerns as to the children's well being remained.
3. **Socioeconomic, systemic and personal (i.e. denial) barriers exist that create difficulty in accessing treatment. (E.g. transportation, waiting lists, childcare, denial of problem, non-supportive partner, etc.).**

I will not be attempting to duplicate existing services but rather to provide *extra* support to the women during this difficult change process and to provide extra information to the protection workers through the Personal Action Plans that each participant will develop for themselves during this process. There will be an expectation of group members to utilize

other community supports such as Alcohol and Drug Services and 12 Step programs, and as a part of the process we will collaboratively track their participation in these areas.
The primary goal for the group process will be to empower and motivate the participants to address their AOD issues through the development of a Personal Action Plan based on their course participation and a self-assessment of their individual needs and the community resources that are available to them. This Personal Action Plan is then to be presented to the participant's caseworker for review and approval.
I will conduct an initial interview of selected candidates at which time I will conduct a pre-test, using the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). This test determines which stage in the change process an alcohol abuser is in, on the continuum defined by Prochaska and DiClemente, *from pre-contemplation, contemplation, determination, action or maintenance.* The same instrument will be applied at the end of the group process to evaluate any movement towards the action phase. A further scale, the Allen Barriers to Treatment Instrument, will be applied at the inception of the group to define the barriers that exist for *these* women in *this* community and to help plan to overcome these.
Recognizing the importance of the sequencing of treatment in multi-problem families, it is hoped that this process will provide you with information that will assist in determining the priority in which identified problems can best be addressed. A goal of this psycho-educational process is to help to ensure that the client is invested in any change efforts undertaken, due to the collaborative process of problem identification.
It will be assumed and encouraged that abstinence will be maintained during the group; based on the belief that no work on any issues can be accomplished until sobriety is achieved. The group participants will collectively define group rules and establish what the consequence of 'using' will be. Childcare will be available if needed.
If I may respond to any questions or concerns please give me a call.
My sincere thanks for making this project possible.

Yours Truly,

Adele Kupp, BSW, MSW Candidate

cc. Annette Dowling, Practicum supervisor

APPENDIX VI

(Personal Action Plans)

My Personal Action Plan

This contract is my commitment to myself.

It reflects my willingness to honestly work at developing my talents and abilities.
I will apply an open minded approach to learning and developing new life skills which will serve me better and empower me to achieve my personal life goals.
As I work this plan, I will be learning to grow and participate in a drug and chemical free environment.
For this process to work, I must have clear and achievable goals with simple workable steps and time frames that make it possible for me to reach these goals, one day at a time.

Signature: _____ . Date: _____ .

My Personal Action Plan

Work Book

Guidelines: This WorkBook is designed to help you achieve the life goals that you set for yourself in your Personal Action Plan.

CHANGES & CHOICES

NOTES:

This WorkBook belongs to: _____ .

Life Goals

1) Goals For Personal Development

Emotional

Develop a list

For example:

- Express anger in a new way.
- Develop another less harmful word or expression to replace your 'favorite swear word.
- Have a good cry.
- Identify a good thing about yourself each time you find yourself thinking that badly about yourself.
- Do something that is sure to give you a belly laugh.

Notes:

Physical

Develop a 'to do' list of personal:

- habits,
- hobbies
- other activities

that you would like to do or used to do, that you haven't done lately.

For example:

Morning walks / see a dentist / go to the gym/ play ball with the kids

concerns	habits	hobbies	other activities

Make another list describing the first step needed for each item that you have identified to happen.

Spiritual

Find at least one new thing each day to be grateful for
and thank your inner or higher power for it

There are endless examples. Discover the ones that work for you.

not being alone / being warm /
having choices / a snowflake / being....

My First Gratitude List

2) Support Network

name	number	date called	comments

3) Family and Friends

The people who I can count on for support are:

person	type of support

The people whose trust I have lost and would like to regain are:

person	what I need to do	when

notes:

Slippery Places (people and things)

People that I need to avoid - to stay and grow, sober and straight

person	reason

Places that I need to avoid

place	reason

Things that I need to avoid (or avoid doing)

thing	reason

4) Intimate relationships

What that means to me _____

_____

_____

Characteristics of an intimate relationship _____

_____

_____

Personality traits that I admire in the other person

_____ _____

_____ _____

Characteristics that I look for in the other person

_____ _____

_____ _____

Characteristics that I <u>don't</u> want or like in the other person

_____ _____ _____

_____ _____ _____

5) Educational Development

a) List the five things that you have always wished you knew more about (space, biology, computers, counseling, etc.)

1) _____

2) _____

3) _____

4) _____

5) _____

b) List the papers, permits, diplomas, and licenses that you would most like to have.

_____ _____

_____ _____

_____ _____

_____ _____

6) Goals for my working career.

a) Getting started: what kinds of jobs can I work at as soon as my 90 days are completed.

_____

_____

_____

b) The perfect job: My first three choices

	Job	What do I have to do to get there?
1)	_____	_____
2)	_____	_____
3)	_____	_____

Notes:

_____

_____

_____

My Fellowship

Choosing a Fellowship

Most of us have a drug of choice (alcohol, marijuana, cocaine, etc.) that we use more than any other. Fortunately, the same twelve steps are used in all twelve-step programmes. ***That's because they work!*** If you have ever used more than one drug, then don't be shy about using more than one fellowship!

As a guideline, look hardest at the Fellowship that matches your drug of choice. Ultimately, after all the advice has been given, it's your choice. Only you will know what will work best for you.

Things To Look For:

1) Number of meetings per week, per day _____

_____

2) Number of groups _____

_____

3) Size of membership _____

_____

4) Length of sobriety (clean time) of the membership _____

_____

5) Availability of potential sponsors _____

_____

Choosing a Group

Things To Look For:

1) number of meetings per day, per week _____

_____

2) Location (walking distance, near a bus route) _____

_____

3) Size of the group (number of members) _____

_____

4) Length of sobriety of the membership _____

_____

5) Availability of potential sponsors _____

_____

6) Tolerance to other addictions _____

_____

Choosing a Sponsor

Things To Look For:

1) Length of sobriety _____

_____

2) Quality of sobriety _____

_____

3) Programme knowledge _____

_____

4) Availability _____

_____

5) Finally, does she have the kind of programme that you would like to have?

Yes _____ No _____ .

Note: Most Fellowships have lists of members who will be temporary sponsors, who will act as guides and provide assistance until you have had a chance to get settled.

APPENDIX VII

(Evaluation Questionnaire)

Changes and Choices

...the questionnaire

How'd we do?

Thank you.

This questionnaire is intended to help me identify what worked best for you in the group, as well as things that were not helpful for you. Sharing your insight on the group process will allow me to improve future groups, as well as assisting me with the final analysis of my academic endeavors.

This questionnaire is confidential and you do not need to identify yourself by signing it. Your thoughts and learning are of great value to this process and I thank you for sharing them.

To ensure your confidentiality, please put your completed questionnaire in the envelope provided and seal it. Then give the envelope to Annette Dowling who will compile the information in a format that will ensure your privacy and confidentiality is maintained. She will then return the compiled information to me. Again my heart felt thanks for making Changes & Choices possible.

Adele

Guidelines: Please circle the number that is closest to your feelings about the following questions or statements-

With **1** being **very poor**, **2 poor**, **3 average**, **4 good** and **5 excellent**.

Circle the number that is closest to how you judge each item.

Please feel free to comment after each item to explain your answer.

The Beech Crescent community house as a setting.

1 2 3 4 5

Monday and Friday Mornings as group time.

1 2 3 4 5

The day care provided.

1 2 3 4 5

The transportation provided.

1 2 3 4 5

The group being women only.

1 2 3 4 5

---

8 weeks of group meetings

.1 2 3 4 5

The size of the group.

1 2 3 4 5

The sessions on gender issues.

1 2 3 4 5

The sessions on shame and stigma.

1 2 3 4 5

The speakers from the AA and NA community.

1 2 3 4 5

The sessions on family issues.

1 2 3 4 5

The handouts that were given.

1 2 3 4 5

The time for discussion.

1 2 3 4 5

The workshop on relationships by Alcohol and Drug worker.

1 2 3 4 5

The communication with the Ministry workers.

1 2 3 4 5

The check-in process.

1 2 3 4 5

The music.

1 2 3 4 5

The candles.

1 2 3 4 5

The time to be creative - ie collages and poetry.

1 2 3 4 5

What was the best part of the group experience?

What was the worst part of the group experience?

How do you feel about substance abuse now? Any differently?

Do you feel that you could turn to the other women in the group for help?

What general effect, if any, has this group had on your life?

What are some changes in your life that you feel the group had a part in?

What was your experience with the group facilitator (Adele)?

Did the facilitator listen to you?

1 2 3 4 5

Did the facilitator give you an opportunity to be heard?

1 2 3 4 5

Did you feel that the facilitator understood what you had to say?

1 2 3 4 5

Did you think that the facilitator knew a lot about the subject of Addictions?

1 2 3 4 5

What could the facilitator have done differently to be more helpful?

1 2 3 4 5

Overall, how would you rate your experience with the facilitator?

1 2 3 4 5

The overall rating that you would give this group.

1 2 3 4 5

APPENDIX VIII

(ABTI Measurement)

ALLEN BARRIERS TO TREATMENT INSTRUMENT

Listed below are reasons that sometimes keep people from getting help. Based on what you are experiencing, have experienced, or have heard about, how much does each of the following treatment program characteristics keep you from getting treatment for alcohol or other drug problems?

CIRCLE one number for each statement.

		This Keeps Me From Getting Help... A Lot	An Average Amount	A Little	Not At All
1.	Not knowing the location of treatment programs.	4	3	2	1
2.	Having to wait for an opening because the program is full.	4	3	2	1
3.	The behavior of treatment program staff toward patients.	4	3	2	1
4.	Possibly having to talk of my problem with a male counselor.	4	3	2	1
5.	The far distance of treatment programs from my home.	4	3	2	1
6.	No available transportation to the treatment program	4	3	2	1
7.	Possibly having to talk in a group where men are present	4	3	2	1
8.	Treatment programs that have men as well as women patients	4	3	2	1
9.	No help from treatment programs for staying alcohol-free and/or drug-free afterwards	4	3	2	1
10.	No confidence in treatment programs teaching me what I need to know as an alcoholic or drug-abusing woman	4	3	2	1

What other things about treatment programs keep you from getting help?

Based on what you are experiencing or have experienced, how much does each of the following personal beliefs, feelings, or thoughts, keep you from getting treatment for alcohol or other drug problems?

CIRCLE one number for each statement.

		This Keeps Me From Getting Help... A Lot	An Average Amount	A Little	Not At All
11.	I feel ashamed when I admit to having this problem.	4	3	2	1
12.	In the past I have been unable to stay alcohol-free and/or drug-free after treatment.	4	3	2	1
13.	I cannot pay for treatment of this problem.	4	3	2	1
14.	I do not have health insurance for this problem.	4	3	2	1
15.	I do not trust doctors, clinics, or hospitals to help.	4	3	2	1
16.	I do not feel that drinking and drug use is a problem for me.	4	3	2	1
17.	I do not let health problems interrupt my life.	4	3	2	1
18.	I have religious beliefs about this problem.	4	3	2	1
19.	I have responsibilities at home as a mother, wife, or partner.	4	3	2	1
20.	I was raised to believe I should take care of my own health problems.	4	3	2	1

What other personal beliefs, feelings, or thoughts keep you from getting help?

Based on what you are experiencing or have experienced, how much does each of the following issues keep you from getting treatment for alcohol or other drug problems?

CIRCLE one number for each statement.

	This Keeps Me From Getting Help... A Lot	An Average Amount	A Little	Not At All
21. No encouragement from family and friends to get help for the problem.	4	3	2	1
22. Not being accepted by my friends if I am alcohol-free and/or drug-free.	4	3	2	1
23. Having no one in my family or community to take care of my children.	4	3	2	1
24. Having no meetings or programs in my community to help me stay alcohol-free and/or drug-free.	4	3	2	1
25. Anger from my boyfriend, husband, or lover for being alcohol-free and/or drug-free.	4	3	2	1
26. The fear that my admission of this problem could be used by someone to take my children away.	4	3	2	1
27. Not being able to get time off from work.	4	3	2	1
28. Living in a community where everyone is expected to party using alcohol or drugs.	4	3	2	1
29. Being protected from the bad results of my alcohol and/or drug problem by friends, family or coworkers.	4	3	2	1
30. Needing alcohol and/or drugs to deal with the stress of daily life in my community.	4	3	2	1

What other issues keep you from getting help?

CIRCLE the number that corresponds with the correct answer and fill in the blank where lines are provided.

31. Religion:

Protestant	1
Catholic	2
Jewish	3
Islamic	4
Other	5
None	6

32. Do you attend religious services on an average of:

Less than once a month	1
Once a month	2
Twice a month	3
Three times a month	4
Four times a month	5
More often than that	6

33. Have you ever been detoxed for alcohol or drug abuse? _____ and have you ever had treatment for alcohol or drug abuse? _____

APPENDIX IX

(SOCRATES Measurement)

Personal Drinking Questionnaire
(SOCRATES 8A)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

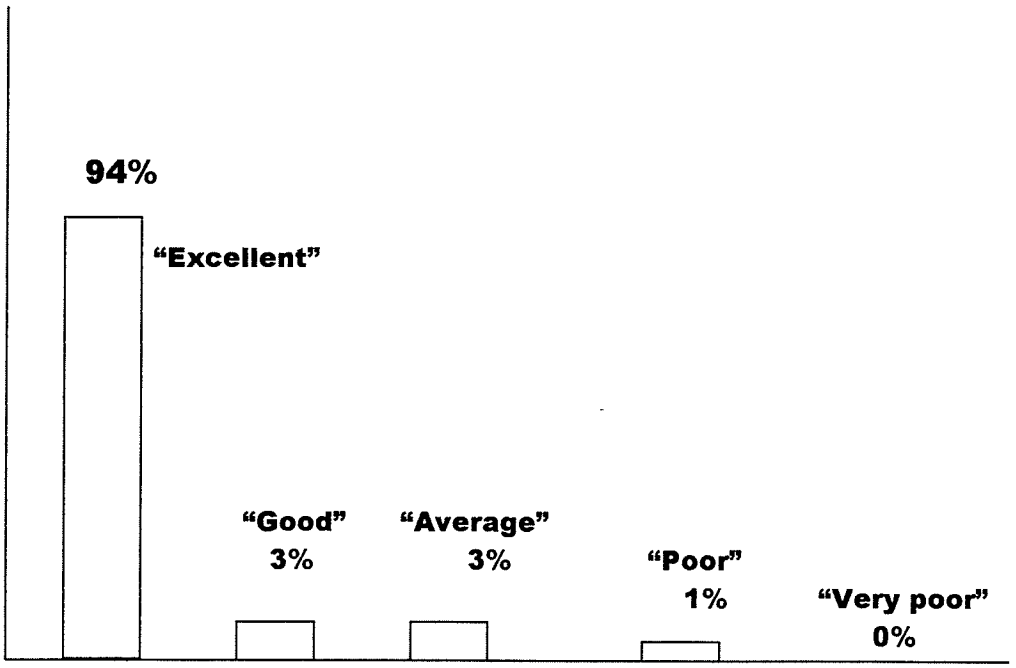
	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
1. I really want to make changes in my drinking.	1	2	3	4	5
2. Sometimes I wonder if I am an alcoholic.	1	2	3	4	5
3. If I don't change my drinking soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drinking.	1	2	3	4	5
5. I was drinking too much at one time, but I've managed to change my drinking.	1	2	3	4	5
6. Sometimes I wonder if my drinking is hurting other people.	1	2	3	4	5
7. I am a problem drinker.	1	2	3	4	5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drinking.	1	2	3	4	5

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
11. Sometimes I wonder if I am in control of my drinking.	1	2	3	4	5
12. My drinking is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop drinking.	1	2	3	4	5
14. I want help to keep from going back to the drinking problems that I had before.	1	2	3	4	5
15. I know that I have a drinking problem.	1	2	3	4	5
16. There are times when I wonder if I drink too much.	1	2	3	4	5
17. I am an alcoholic.	1	2	3	4	5
18. I am working hard to change my drinking.	1	2	3	4	5
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	1	2	3	4	5

APPENDIX X

Changes and Choices

Evaluation Questionnaire
Responses Expressed as a Percentage



Percentage of responses

REFERENCES

Abbott, A. (1995). Substance Abuse and the Feminist Perspective. In (Ed.) Van Den Bergh *Feminist Practice in the 21st Century*, Washington DC: NASW Press. 258-277.

Allen, K. (1994). Development of an instrument to identify barriers to treatment for addicted women, from their perspective. *The International Journal of Addictions. 29* (4). 429-444.

Allen, K. & Dixon, M. (1994). Psychometric assessment of the Allen Barriers to Treatment Instrument. *The International Journal of the Addictions.* 29(5). 545-563.

Akin, B. & Gregoire, T. (1997). Parents views on Child Welfare's response to addiction. *Families in Society: The Journal of Contemporary Human Service July-August 1997.* 393-404.

ALCOHOLICS ANONYMOUS. (1955) New York: Alcoholics Anonymous World Services.

Azzi-Lessing, L., & Olsen, L. (1996). Substance abuse affected families in the Child Welfare system: New challenges, new alliances. *Social Work, 41* (1), 15-23.

Beckman, L., & Amaro, H. (1984). Patterns of Women's Use of Alcohol Treatment Agencies. *Alcohol Health and Research World.* Winter 1984/85. 15-22.

Beckman, L., & Kocel, K. (1982). The treatment delivery system and alcohol abuse in women: social policy implications. *Journal of Social Sciences. 38* (2). 139-151.

Belenky, M., Clinchy, B., Goldberger, N., & Tarule, J. (1986). *Women's Ways of Knowing: The Development of Self, Voice, and Mind.* USA: Basic Books.

Bepko, C. (1991). Disorders of power: Women and addiction in the family. In McGoldrick, M., Anderson, C. & Walsh, F. (Eds.), *Women in Families; A Framework for Family Therapy.* New York: W.W. Norton & Company. 407-426.

Bepko, C. & Krestan, K. (1985). *The Responsibility Trap: a Blueprint for Treating the Alcoholic Family.* New York: The Free Press.

Blau, G., Whewell, M., Gullotta, T., Bloom, M. (1994). The prevention and treatment of child abuse in households of substance abusers: A research demonstration progress report. *Child Welfare, LXXIII.* 83-95.

Bowen, M. (1972). *Family Therapy in Clinical Practice,* Northvale, New Jersey: Jason Aronson Inc.

Burman, S. & Allen-Meares, P. (1991). Criteria for selecting practice theories: Working with alcoholic women. *Families in Society: The Journal of Contemporary Human Services.* September, 1991. 387-393.

Callahan, M. (1993). Feminist approaches: Women recreate Child Welfare. In B. Wharf (Ed.), *Rethinking Child Welfare in Canada_* Toronto: McClelland and Stewart Inc. 172-209.

Carten, A. (1996). Mothers in recovery: Rebuilding families in the aftermath of addiction. *Social Work, 41.* 214-223.

Carter, B., and McGoldrick, M. (1980). *The Family Life Cycle.* New York: Gardner Press.

Carter, B., and McGoldrick, M. (1988). *The Changing Family Life Cycle: A Framework For Family Therapy.* 2nd ed.: Boston: Allyn and Bacon.

Chapman, C. (1997). Dual relationships in substance abuse treatment: Ethical implications. *Alcoholism Treatment Quarterly. 15* (2). 73-79.

Corey, M. & Corey, G. (1977/1992). *Groups: Process and Practice.* California: Brookes Cole Publishing Company.

Finkelstein, N. (1994). Treatment issues for alcohol - and drug - dependent pregnant and parenting women. *Health & Social Work 19* (1). 7-15.

Finkelstein, N. (1996). Using the relational model as a context for treating pregnant and parenting chemically dependent women. *Journal of Chemical Dependency Treatment 6* (1/2). 23-44.

Finkelstein, N., Kennedy, C., Thomas, K., & Kearns, M. (1997). *Gender Specific Substance Abuse Treatment,* National Women's Resource Center, Center for Substance Abuse Prevention. Available on-line, http://www.nwrc.org/respkg.htm:
Date accessed-April, 1998.

Gelles, R. (1993). Alcohol and other drugs are associated with violence - they are not its cause, *Current Controversies in Family Violence,* Gelles, R. and Loske, D., Eds. California, Sage Publications. 182-196.

Gurman, A., and Kniskern, D. (Eds.) (1991). *Handbook of Family Therapy Vol. 1.* New York: Bruner/Mazel, Inc.

Hagan, K. (1995). Codependency and the myth of recovery: A feminist scrutiny. In Babcock, M. & McKay, C. (Eds.), *Challenging Codependency: Feminist Critiques.* (pp. 198-206).Toronto: University of Toronto Press.

Haley, J. (1980) *Leaving Home, The Therapy of Disturbed Young People.* USA: Library of Congress.

Hanson, M., Foreman, L., Tomlin, W. & Bright, Y. (1994). Facilitating problem drinking client's transition from inpatient to outpatient care. *Health and Social Work, 19* (1). 23-28.

Hughes, P., Coletti, S., Neri, R., Umann, C., Stahl, S., Sicilian, D., & Anthony, J. (1995). Retaining cocaine-abusing women in a therapeutic community: The effect of a child live-in program. *American Journal of Public Health, 85.* 1149-1152.

Imber-Black, E. (1991). The family-larger system perspective. In Gurman, A., and Kniskern, D. (Eds.), *Handbook of Family Therapy, Vol.2.* New York: Bruner/Mazel Inc. 583-605.

Issacson, E. (1991). *Chemical Dependency: Theoretical Approaches and Strategies Working With Individuals and Families.* New York : The Haworth Press.

Kerr, M. & Bowen, M. (1988). *Family Evaluation.* New York: Norton.

Luepnitz, D. (1988). *The Family Interrupted, Psychoanalysis, Feminism and Family Therapy,* U. S. A.: Basic Books.

McGoldrick, M., Anderson, C., and Walsh, F. (Eds.). (1989). *Women In Families, A Framework for Family Therapy,* New York: W. W. Norton and Company.

Meyers Avis, J. (1986). Feminist issues in family therapy, *Family Therapy Source Book,* Piercy and Sprenkle Eds. Guilford Press. 215-230.

Miller, A. (1988) *Banished Knowledge, Facing Childhood Injuries,* New York, New York: Doubleday.

Morton, C. (1998). *Children's Commissioner Annual Report.* Province of British Columbia, Queen's Printer.

Nelson-Zlupko, L., Kauffman, E., & Morrison Dore, M. (1995). Gender differences in drug addiction and treatment: Implications for social work intervention with substance-abusing women. *Social Work, 40* (1), 45-54.

Nichols, M., & Schwartz, R. (1995). *Family Therapy, Concepts and Methods.* Boston: Allyn and Bacon.

Papp, P., & Imber-Black, E. (1996). Family themes: Transmission and transformation. *Family Process, 35* 5-21.

Powel, B. (1997). Collaborative notes. *Journal of Collaborative Therapies, 5(1).* 18-21.

Prochaska, J., DiClemente, C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist.* September, 1992. 1102-1114.

Richardson, R. (1987*). Family Ties That Bind.* Vancouver: Self-Counsel Press.

Robbins, S., Chatterjee, P., & Canda, E. (1998). *Contemporary Human Behavior Theory a Critical Perspective for Social Work.* Allyn and Bacon. Toronto.

Root, M. (1989). Treatment failures: The role of sexual victimization in women's addictive behavior. *American Journal of Orthopsychiatry, 59(4).* 542 - 549.

Schaef, A. W. (1992). *Beyond Therapy - Beyond Science,* Harper Collins Publishers.

Stanton, M., Todd, T., and Associates, (1982*). The Family Therapy of Drug Abuse and Addiction,* New York: The Guilford Press.

Steinglass, P. (1987). *The Alcoholic Family,* New York: Basic Book Publishers.

Swift, K. (1991). Contradictions in Child Welfare: Neglect and Responsibility. In Bains, C., Evans, P., & Neysmith, S. (Eds.*) Women's Caring Feminist Perspectives on Social Welfare.* M&S. 234-270.

Tallen, B. (1995). Codependency: A feminist critique. In Babcock, M. & McKay, C. (Eds.), *Challenging Codependency: Feminist Critiques.* Toronto: University of Toronto Press. 198-206.

Toseland, R. & Rivas, R. (1984). *An Introduction to Group Work Practice.* New York: Macmillan Publishing Company.

Wallen, J. (1993). *Addiction in Human Development: Developmental Perspectives on Addiction and Recovery,* New York: The Haworth Press.

Wilke, D. (1994). Women and alcoholism: How a male-as-norm bias affects research, assessment and treatment. *Health and Social Work, 19. (1).* 29-35.

Zuskin, R., & DePanfilis, D. (1995). Child Protection Services: Working with CPS families with alcohol or other drug (AOD) problems. *The APSAC Advisor, 8, (1).* 7-12.